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# LEGISLATION PERTAINING TO VETERANS' HEALTH CARE, COMPENSATION, AND OTHER BENEFITS PROGRAMS

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## HEARING

BEFORE THE

## COMMITTEE ON VETERANS' AFFAIRS
## UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

ON

## S. 1536, S. 2168, S. 2174, S. 2304, S. 2388, S. 2422, S. 2423, S. 2445, and Related Bills

MAY 20, 1986

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# LEGISLATION PERTAINING TO VETERANS' HEALTH CARE, COMPENSATION, AND OTHER BENEFITS PROGRAMS

TUESDAY, MAY 20, 1986

U.S. Senate,
Committee on Veterans' Affairs,
*Washington, DC.*

The committee met, pursuant to notice, at 9:35 a.m., in room SR-418, Russell Senate Office Building, Anthony J. Principi (chief counsel), presiding.

Present: Senators Specter, Cranston, and Mitchell.

Also present: Senator Heinz.

## OPENING STATEMENT OF ANTHONY J. PRINCIPI, CHIEF COUNSEL, U.S. SENATE COMMITTEE ON VETERANS' AFFAIRS

Mr. Principi. Good morning and welcome to the Senate Committee on Veterans' Affairs.

This morning the committee is meeting to consider various legislative items pending before the committee in health care, compensation, and other VA benefits. Unfortunately, the chairman was taken ill on a swing through his home State over the weekend and was grounded by his doctor in Alaska and is unable to be with us.

I understand that Senator Cranston, the ranking minority member is en route from his State of California and will be with us hopefully later this morning, as well, I hope that other members of the committee will be here.

In view of the array of legislative items pending before the committee and the late hour and the work that needs to be done to move these legislative items through the process, the chairman requested that I convene in his absence. I certainly ask your indulgence so that we can get on with the task before us.

I would ask, if there is no objection, that the chairman's opening statement be inserted in the record as if read. Copies have been made available to you; I believe they are on the press table if you care to pick one up.

[The prepared statement of Chairman Murkowski appears on p. 29.]

Mr. Principi. If you have no objection then, we will hear from our first panel of witnesses. Welcome, Dr. Ditzler; Mr. Vogel; Mr. Horton; general counsel, Mr. Ivers; Dr. Brown; and Mr. Lindsey.

Welcome, gentlemen. You may proceed at will.

## STATEMENT OF DR. JOHN W. DITZLER, CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY R. JOHN VOGEL, CHIEF BENEFITS DIRECTOR; DONALD L. IVERS, GENERAL COUNSEL; GRADY W. HORTON, DEPUTY CHIEF BENEFITS DIRECTOR; DR. D. EARL BROWN, JR., ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR; ROBERT E. LINDSEY, JR., DIRECTOR OF OPERATIONS; DR. PAUL ERRERA, DIRECTOR, MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE; AND ROBERT M. O'TOOLE, DIRECTOR, LOAN GUARANTY SERVICE

Dr. **Ditzler**. Thank you, Mr. Chairman. I am pleased to be here this morning to present the VA's views, concerning health care legislation pending before the committee. Mr. John Vogel is also here to testify concerning benefit program legislative proposals.

Also with me at the witness table are Mr. Robert Lindsey, Director of Operations; Dr. Earl Brown, Associate Deputy Chief Medical Director for Programs, Planning and Policy Development; and Mr. Donald Ivers, general counsel, along with Mr. Vogel and Mr. Horton.

Mr. Chairman, our formal testimony presents the VA views concerning each legislative proposal on today's agenda. In the interest of time I will make general comments and then along with staff with me today be prepared to respond to the committee's questions.

You have before you many innovative proposals for consideration. I am particularly pleased, for example, at the introduction of a proposal for a respite care pilot program. With certain changes we would support the proposal to expand noninstitutional options for our chronic mentally ill patient population, which would help bring VA psychiatric care to the forefront in treating this type of patient population.

We also favor development of additional noninstitutional options for all of our patients. However, we believe that such options should be limited to postdischarge from a VA inpatient program and be limited to services of a medical nature.

Mr. Chairman, we also appreciate your introducing our proposal that would require non-Federal providers of health care under the Medicare Program to accept VA patients on an equal cost basis.

We appreciate your interest in trying to work out a solution for needed parking facilities at many medical centers, and we look forward to working toward a mutually acceptable solution.

We also welcome the considerations of Senator Cranston's proposals to provide, for example, added authority for VA police officers to enforce State and local traffic laws on VA property; authorization of bereavement counseling in certain circumstances; revision of domiciliary eligibility; and for an extension of expiring VA programs.

Our formal testimony makes the proposal to modify other proposals before the committee today.

With these brief remarks, Mr. Chairman, I will turn now to Mr. John Vogel, the Chief Benefits Director, to present comments on benefit program proposals on today's hearing agenda.

Mr. **Principi**. Thank you, Doctor.

Dr. **Ditzler**. Thank you.

Mr. **Principi**. Mr. Vogel.

[The prepared statement of Dr. Ditzler appears on p. 57.]

Mr. VOGEL. Thank you, Dr. Ditzler.

Mr. Chairman, the VA strongly supports the December 1, 1986, cost-of-living increase for disability compensation [DIC], and the associated benefits enumerated in title I of S. 2422, to help offset the erosion of purchasing power resulting from increases in consumer prices. We favor a percentage increase for VA disability compensation and DIC rates equal to that required by law for Social Security recipients.

Title II of S. 2422 would modify certain procedures relating to VA's acquisition of foreclosed property under the Home Loan Guaranty Program by providing the Administrator authority not to acquire certain properties which would be difficult to sell.

Under the bill, a loan holder would not be permitted to convey to VA unless the Administrator determines that the property can be sold within 1 year at an economically advantageous price.

VA has attempted to take poor local market conditions into account in appraising property. Nevertheless, some properties may sell very slowly, even at depressed market values. Therefore, it may be useful to have some flexibility to decide to decline to accept properties which cannot be sold within a reasonable time.

Accordingly, the VA has no objections to the basic purpose of this measure. We have, however, in our prepared testimony detailed technical problems with two features of the bill which deserve your staff's attention.

Title III of S. 2422 contains three provisions other than the parking fund proposal Dr. Ditzler has already discussed. The first of these, section 301, would amend section 3101 of title 38 to permit the Department of Defense to recover overpayments of military retired pay and retainer pay and delinquent survivor benefit plan and retired serviceman's family protection plan premium payments from VA disability compensation and pension. Overpayments frequently occur due to the concurrent eligibility of many veterans for dual DOD and VA benefits.

Premium arrearages for SBP and RSFPP separately cause serious problems for DOD's administration of the coverage. DOD supports legislation to relieve these problems. Section 301 would enable the efficient and equitable recovery of these targeted overpayments, as well as collection of delinquent premium payments.

The second provision of title III, section 302, would require a greater degree of accountability on the part of fiduciaries. Section 3202(b) of title 38 presently authorizes the Administrator to require, from fiduciaries appointed or recognized by the VA, accounting of the uses of VA benefits for their wards. The law, however, is not clear about the Administrator's authority to require the fiduciary to furnish other information to non-VA sources.

We believe VA oversight of the proper use of benefits would be significantly enhanced by clear authority to require full disclosure.

I would also like to comment briefly on section 304 of S. 2422. In order to improve the VA's delivery of services and achieve a more appropriate organizational alignment, the Administrator, on February 5, 1986, notified Congress that he intended to implement an administrative reorganization within VA Central Office which would involve the transfer of two functions from the Office of Administration. Specifically, the Presidential Memorial Certificates would come to the Department of Veterans' Benefits, and the Audio Visual Service would be transferred to the Office of the Associate Deputy Administrator for Public and Consumer Affairs.

The PMC Program honors the memory of honorably discharged deceased veterans through the issuance of certificates. This is a benefit service rather than an administrative service, and we believe that it properly belongs in DVB.

Audio Visual Service provides support services for various activities throughout the VA. That transfer would consolidate the VA's outreach and public affairs activities into one element.

As you are aware, because of section 210(b) of title 38, the agency will have to wait until October 1, 1986, to implement this reorganization unless Congress legislatively waives the waiting period. We requested such a waiver in our letter of February 5 in order to allow us to effect these administrative efficiencies in a more timely fashion. This section would provide that waiver, and we, therefore, fully support this section.

We would note that the necessity of reporting and deferring this minor reorganization, involving the transfer of only about 39 FTEE, demonstrates how current law denies the agency the administrative flexibility to promptly restructure operations when necessary to better serve veterans. We strongly urge the repeal of section 210(b)(2).

Another bill under consideration, S. 2168, would add two disabilities to those currently listed as presumptively service-connected for certain prisoners of war. The conditions are frostbite residuals and traumatic arthritis. We question the need for that legislation, since we have no reason to believe that former POWs with such disabilities are being denied benefits.

Finally, I would like to discuss S. 2304, which would provide a 3-year extension on VRA appointments.

We strongly support the extension of that authority. It has been a very efficient means for us to employ Vietnam-era veterans. At the VA, we have appointed more than 85,000 veterans under that authority, in a wide variety of occupations. Extending it for a 3-year period is essentially a cost-free way of helping veterans complete their readjustment to civilian life.

Mr. Chairman, this concludes my remarks. I would be pleased to answer any questions that you or the members of the committee may have.

Mr. PRINCIPI. Thank you.

Most of the questions will be submitted for the record. However, I am told Senator Mitchell joins us. And I understand he is on his way.

In the meantime, perhaps I could just take a moment or two to cover a few areas.

Dr. Ditzler, as I read your testimony last evening, sir, I noted what appeared to perhaps be an inconsistency in your position or perhaps the VA's position with regard to noninstitutional care. You make the statement that you do not recommend a change in the VA's longstanding policy that the DM&S's sole responsibility is to provide medical services to veterans and not home or health related services, daily living services, and that, that is left to the community or other resources.

Yet, later on in your testimony there is support for a pilot project of independent living. Your department also provides spinal cord injured veterans with that kind of home care, alcohol and drug rehabilitation, and on and on.

Is there in fact an inconsistency there with regard to the chairman's position that we extend this authority to you to provide health related services to veterans?

Dr. DITZLER. Mr. Chairman, the inconsistency is apparent, but it is not truly an inconsistency in that the independent living program is already in existence and we are really requesting that it be continued as it is for another several years.

The primary concern that we have as we examine the geriatric population explosion and all of the mandates for care is that if one gets outside of the medical arena and gets into the wide dispersion of resources to societal concerns, it is almost a never ending funding situation and the monitoring of it would be very difficult.

We strongly approve of the idea of outplacement of patients into homes wherever possible, but we believe that the support that we provide should be limited primarily to the medical arena. If we get into providing purely social support services we would have serious problems both in terms of monitoring and cost control.

Mr. PRINCIPI. How about on a pilot project basis?

Dr. DITZLER. The pilot project basis on independent living we would wish to extend because we have been at it a very short time and we really have a small data base on which to make judgments regarding its impact.

I think there is also concern, at least on my part, that it may send the wrong signal that we are going back into the mainstreaming concepts that frightened so many people in the past. And I think that with caution we can approach development of home living support. But when we get into the purely support and assistance areas that other institutions of society could provide, I would be very cautious about approaching that.

The basic principle has been explained and studied in many areas of society by so-called channeling projects in which it has been clearly shown that many of these things do help the individual but they are not cost saving. I believe in this particular time we need to develop programs that are clearly cost-effective additions to our medical programs.

Mr. PRINCIPI. With regard to the Independent Living Pilot Program, how are the responsibilities divided between your department and that of Mr. Vogel? Would it be more appropriate for DM&S to take the lead in this pilot program?

Dr. DITZLER. I am going to ask Mr. Vogel first to respond on that one.

Mr. VOGEL. The nature of the program, Mr. Principi, whether it belongs in DVB or DM&S, I think the point is that the resources of both the departments are brought to bear. We focus on very specific services for those veterans. Where the need is identified for services delivered—administered by the Department of Medicine and Surgery, such as blind rehabilitation or spinal cord injury service, those referrals are made, and they do not fall within the framework of the guidance under the Independent Living Program.

Independent living is a legitimate objective of a rehabilitation program, as such, as a vocational rehabilitation program, and used in combination with a regular vocational rehabilitation program that is administered by DVB. And there is no question that medical rehabilitation is available and used in looking at the total treatment and care for veterans who we believe are candidates for that program.

Dr. BROWN. Mr. Chairman, if I can add to that, just to echo what Mr. Vogel said. As you know, we have six programs in independent living in the Department of Medicine and Surgery wherein we have been taking referrals from DVB. I think that the important thing is that we work very closely together. And when they need a psychologist or an occupational therapist to assist in the skills for independent living the patients are sent to the DM&S and, specifically, to our centers, for such training, so that we work together on this.

I do not think it makes a lot of difference who manages it because it is a well coordinated program.

Mr. PRINCIPI. Thank you.

If I can just shift for a moment to the concept of paid parking. We find ourselves in a situation where a number of parking facilities are urgently needed in areas such as San Francisco, Syracuse, and other locations, and a mandate by the Appropriations Committee that there will be no appropriations for parking facilities until such time as the VA takes a good hard look at the revolving fund and the implementation of paid parking.

We are also getting late in the year and the Appropriations Committees are beginning to put their bills together. In response to this situation the chairman and the ranking minority member have introduced legislation to establishing a paid parking program at new facilities.

In your testimony you seem to support the concept of paid parking. You do not support the legislation the way it is structured. You, I believe, want to defer it to a task force. Is this just a menu to kill paid parking? Are you going to come up with a paid parking program in time for the Appropriations Committees to examine so that moneys will be put into the bill to cover these locations?

Dr. DITZLER. Mr. Chairman, I wish to make three points:

First, that I believe parking in some of our difficult locations, such as San Francisco, is as imperative as building an operating room. And I, frankly, do not understand the reluctance to accept the fact that you must have parking at a modern medical facility.

The second thing that I believe I would emphasize is we have no objection to charging fees. The problem is in determining whether everybody in the system gets charged, whether everybody in a facility gets charged, whether only those who use the new parking facility that is built are charged—we get into a whole series of inequities. But fundamentally, we do not object to payment of fees. The problem of how and who is a vexing one.

The third point I would make on this is that we have objections to a revolving fund in which the potential dollars available for the construction of a new facility is totally dependent on whatever fees go into that revolving fund. It, in essence, would kill future developments of parking. Once one was built, the amount of fees charged, no matter what rate, would probably not achieve enough money in a revolving fund for that purpose.

Therefore, we would propose that this bill be amended to provide that the fees be returned to miscellaneous receipts in the Treasury in support of the United States in general.

I think the issues beyond that are more of a technical/legal one that I would defer to General Counsel on.

Mr. PRINCIPI. Mr. Ivers, do you have anything to add with regard to the VA's position on this matter?

Mr. IVERS. No, only the position as it is stated in the statement there. We have the authority to charge for parking now. We are working on a plan to implement that authority. And we believe that that is probably the best authority. And we propose to do away with the revolving fund concept.

Mr. PRINCIPI. Have you had any consultation with the HUD Independent Agencies Subcommittee of the Appropriations Committee, with regard to your position?

Mr. IVERS. Not to my knowledge at this point. We intend to go to them with a plan when it is developed.

Dr. DITZLER. I think the intent is clearly that we have no objection to charging for parking. Our problem is where do you get the sufficient funds to inaugurate the thing in the beginning? And that requires action, we believe, from an appropriation. And once an Appropriation Committee has initiated the proposal and the funding to get it off the ground, I have no problem with the idea of our continuing a fee program.

But then the question gets to such simple mundane things, if an individual hospital has both level parking and a new parking structure does everybody pay for parking on the level as well as in the garage or only those who park in the garage? There are all kinds of interpretations on that.

Second, does the cost of amortization include only the land or does it include the entire amortization of the structure? If one is putting up a modern parking facility for 1,500 cars, the amortization requirements per individual would be excessive, I believe. So that it does need further elaboration.

Mr. PRINCIPI. Assume for the moment that the Congress proceeded with the revolving fund. Could you provide us with any indication of what the initial appropriation should be to that revolving fund? Twenty-five million? Fifty million? Has the agency given any thought to how much money would be needed to get this program moving?

Dr. DITZLER. I do not think there is an agency position because we generally do not support the revolving fund concept. But I believe that if that is the only option I am sure that it would require an initial deposit of several millions of dollars in order to get it off the ground.

Mr. PRINCIPI. Well, Doctor, I can only assure you that your statement with regard to the importance of parking I think is shared by the members of this committee. I think the question is, How do we find the dollars to provide it? And that unfortunately, eludes us.

Dr. DITZLER. Well, let me, let me emphasize, Mr. Chairman, we do not object to payment of fees. It is a problem of working out the specifics.

Mr. PRINCIPI. Legislation has been introduced with regard to the Medicare fee schedules for payments to the private sector for services provided to veterans. The Disabled American Veterans voice their concern that the use of Medicare fee schedules would place the provision of health care services to disabled veterans on an equal plateau as nonveteran Medicare beneficiaries. How would you respond to that statement?

Dr. DITZLER. I believe that the use of the private sector should be continued where it is most efficient and cost effective in providing quality care. I do not believe, however, we can continue to pay the usual and customary fee charged to the average citizen. Wherever we have done that we literally bankrupted whatever account we have had.

I believe that the current emphasis of cost control in the private sector has markedly affected health care cost which otherwise has been steadily increasing faster than inflation. We would get a better deal, I believe, if we applied the Medicare methodology of payment for VA contract care.

And I welcome the legislative attempt to have us match the same Medicare type of payment program.

Mr. PRINCIPI. In your opinion would that impact adversely on the delivery of health care to veterans in the private sector?

Dr. DITZLER. I do not believe at this time it will because there are a lot of doctors looking for extra work, and there are a lot of hospitals looking for work. In fact, it has gotten to the point where some hospitals will pay all the copayments currently involved in the Medicare Program just to have the workload. So that I do not think the veteran would be adversely affected.

Mr. PRINCIPI. Speaking of the private sector, as we know, the Inspector General reported on the fee basis program in the States of Alaska and Hawaii. I understand Mr. Lindsey may have been to Alaska recently. Do you have any update on any changes in the program in the State of Alaska with regard to the fee basis program?

Dr. DITZLER. I do not think there is any improvement at the moment. I see little or no improvement until we have physical presence there. The physical presence that we currently have is very spotty. And we are having difficulties in employment as well.

So frankly, Alaska is not much different and it will not measurably improve until we get a physical presence there.

Mr. PRINCIPI. Do you see that forthcoming?

Dr. DITZLER. I believe that we can do that. We have a few differences of opinion on how to go about it. But that is in process of submission to the Administrator.

Mr. PRINCIPI. Thank you.

As part of the VA's implementation of the authority to provide psychiatric residential treatment to chronically mentally ill veterans, what steps would you want to take to ensure that veterans receive appropriate followup care? Would you need any additional authority from the Congress to provide those followup mental health care services in the community?

Dr. DITZLER. I am going to defer to Dr. Brown, if you please.

Dr. BROWN. I think I would like to pass this to Dr. Errera.

Mr. PRINCIPI. Your pleasure.

Dr. Errera.

Dr. DITZLER. He is our resident expert on all these matters.

Mr. PRINCIPI. Please take any chair, Doctor.

Dr. ERRERA. Thank you.

Thank you, Dr. Brown.

Mr. Chairman, in informal discussions with general counsel staff, they pointed out to us their preliminary view that the provision of aftercare outside VA facilities in places other than the home are not authorized by law. The preliminary view, therefore, is that VA would need additional authority to provide followup care to patients in community nursing homes or the community group living homes or the shelters that they may be using.

Mr. PRINCIPI. So there needs to be clarification in the law; is that it?

Dr. DITZLER. That is correct.

Mr. PRINCIPI. What, specifically, would you do to implement that?

Dr. ERRERA. The way we would hope to implement it would be to develop mobile teams to provide rehabilitative services to these patients. Professionals would be available to be responsive to the veteran after he or she has left the hospital to go to these places, rather than have the veteran come to the hospital and have all of that kind of disruption.

And the mobile teams would be of three general categories: to be responsive to crises in the community; what we are calling maintenance teams, where we know some people tend to fall apart after certain periods of time; and also some nursing home and elderly housing teams, where we would help these facilities contain these people and also help to be able to bring the patient back to the hospital or back to the community, to facilitate those transfers.

Mr. PRINCIPI. Thank you, Doctor.

Dr. DITZLER. Mr. Chairman, I might point out that this, again, is one of the apparent inconsistencies in what we want to do outside of a hospital. It almost looks like we are departing from the testimony that we want to keep it medical. And I believe Dr. Errera's definition of all these teams really strictly does come within the area of medical care as defined in mental health and medical care. It looks like an inconsistency——

Mr. PRINCIPI. Yes; it does.

Dr. DITZLER [continuing]. But I do not really believe it is.

Mr. PRINCIPI. I appreciate the clarification.

One further question, Dr. Ditzler, and that relates to the 90,000 hospital and nursing home beds requirement which the VA is mandated to operate. Our staff, in visits to VA hospitals around the country, and in talking to administrators, and directors, believe that perhaps this symbolic figure is really impeding the delivery of health care. In view of the declining inpatient census and new modalities of treatment and care, and the use of outpatient clinics, hospital-based home care, does this requirement hurt the delivery of care?

Can you just state to the committee your general views with regard to that provision?

Dr. DITZLER. I do not wish to make light of our responsibilities under law, but I believe there are other laws that the Congress has also passed which require us to deliver efficient health care. Congress has directed us to provide a complete health care system which includes various programs that are ambulatory, that are nonhospital. They have directed us to provide a modern health care system, which in today's world emphasizes ambulatory care and deemphasizes beds. So that we are in a catch-22 if we are viewed as subject to an absolute in the 90,000 bed minimum while at the same time providing excellent medical care by decreasing the number of days of hospitalization.

There is also the issue of appropriate funding of medical care. If it is provided in the ambulatory care and increases the number of veterans seen, then there are less dollars available for staffing all beds. So it is essentially a catch-22.

On the other hand, from the standpoint of having some planning horizon, I think 90,000 is perfectly fine. It allows us to plan for one option that no one seems to want to mention too frequently, and with understanding, and that is the eventuality of another war. We are, by law, a primary backup of DOD. And so to that degree, from a planning point of view I think it is perfectly fine to have a certain optimum horizon. But I do not believe that technically it can be achieved at the same time as providing all the other elements of modern health care.

So I think it has to be dealt with delicately. And I approve of the recommendation the committee has offered.

Mr. PRINCIPI. Shifting over to Mr. Vogel. Mr. Vogel, one of the items included in the chairman and the ranking minority member's bill relates to the Home Loan Guaranty Program, and the concern that your department is buying back an unreasonable number of properties, especially in areas such as Houston. Would you please relate to the committee the current status of the Loan Guaranty Program in that part of the country and what steps you have taken to come to grips with the situation there?

Mr. VOGEL. The situation in Houston is not unlike, but larger in scale, than that which we find in the other Texas regional offices, Waco, in Cleveland, in Denver, and in Los Angeles. Those offices have 43 percent of our foreclosures. And just alone Houston and Waco have 25 percent.

We have emphasized to the appraisers and as well as to our loan guaranty personnel, in Houston specifically, about the value assigned on appraisals. We have gotten the message across, I think, at last, that the area fee appraisers' appraisals should relate to the market value, that means what the property will sell for, rather than to harken back to the days of yore and perhaps the promise of the future.

We, in the month of April, Mr. Chairman, refused to purchase property in 25 percent of all the foreclosure cases in Houston. In May, we increased the figure to 32 percent. We believe that as far as future acquisitions are concerned those properties will only be those that are readily salable. We are paying claims at higher numbers.

Those provisions in the legislation, the proposed legislation, about providing criteria to the VA whether or not to acquire a property, we believe that would be helpful to us. We suggest the criteria be such things as the size of the VA's inventory, the current real estate conditions, as well as the local and national economic conditions, comparison of defaults last year versus this year, and look at the number of defaults in the pipeline and the number of foreclosures. We also look at where the property is located. The realization is that the price of domestic oil is down; it was the base, underlying economy in the Houston, TX, area. It has to be a thing we take into consideration much stronger than we have in the past. There is vigorous economic health in some parts of the country and very poor economic health in Houston.

We have a team of—Mr. Horton would like to offer something.

Mr. HORTON. Yes; I was going to mention, Mr. Principi, that we have sent a team in there of 11 individuals to help with their workload. We have given them staffing support and overtime to help with this particular problem in Houston.

We did that at a time when resources were very scarce, but we thought the situation warranted it.

Mr. PRINCIPI. What is the current number of houses in the inventory in both Houston and Waco? What percentage of your entire inventory is located in that one State?

Mr. HORTON. Approximately 7,000 properties in the 2, and about 25 percent of our inventory countrywide.

Mr. PRINCIPI. What percentage of the properties that are currently in foreclosure are you acquiring?

Mr. HORTON. We are acquiring approximately 30 percent at this time. We are paying off the loan on approximately 30 percent at this time.

Mr. PRINCIPI. In your statement you referred to the fact that when VA determines if it will be to the Government's advantage to acquire and dispose of a property in most cases you use a figure of 10.5 percent to represent your costs. Yet, the fact is that in places such as Houston you are only recouping about 70 percent of the cost of acquiring and marketing the property. How do you reconcile those two figures? You tell us 10.5 percent are your costs of acquiring and disposing of the property. Am I correct that you only recoup about 70 percent of the cost, so your cost is more like 30 percent? Or do I have my figures backward?

Mr. HORTON. Mr. O'Toole maybe can respond to this.

Mr. PRINCIPI. Thank you, Bob.

Mr. O'TOOLE. First of all, 10.5 percent cost figure that we use to take off from the market value of the property is a figure based on our costs in all the regional offices. We do not do an individual, local office analysis of what those costs are.

The reason for the difference between the costs and the loss per property is they are two different things. What you are looking at in the loss per property is what the marketing losses are. The 10.5 percent reflects what the actual administrative and holding costs are—the commission, the management fees, all those sorts of things.

Mr. PRINCIPI. Do you think 10.5 percent is accurate?

Mr. O'TOOLE. We just did a recent analysis and that figure changed recently. The 10.5 is accurate based on what our costs were in the last fiscal year.

Mr. PRINCIPI. Thank you.

Thank you very much. We have additional questions which we would like to submit for the record.

Again, I apologize for the chairman's illness and that he could not be with us this morning. We certainly will apprise him of the material we covered.

Again, my thanks.

[The questions from Chairman Murkowski and the responses appear on p. 397.]

Mr. Principi. I would like to bypass panel 2 for just a moment and ask Mr. William J. Carney, administrator of the Maine Veterans' Home, if he would please come forward and testify.

## OPENING STATEMENT OF SENATOR MITCHELL

Senator MITCHELL [presiding]. Mr. Carney, welcome. We appreciate your coming down to testify. Before you do I will ask that a detailed statement of mine be inserted in the record at the appropriate point as though read.

[The prepared statement of Senator Mitchell appears on p. 42.]

Senator MITCHELL. I apologize to the previous witnesses for not having been able to be here during their testimony. But we will review their testimony carefully. And I do have a number of questions in writing for them.

Mr. Carney, we would be pleased to hear from you now.

[The questions from Senator Mitchell and the responses appear on p. 429.]

## STATEMENT OF WILLIAM J. CARNEY, ADMINISTRATOR, MAINE VETERANS HOME, AUGUSTA, ME

Mr. CARNEY. Thank you very much, Senator Mitchell.

Mr. Chairman and distinguished members of the Senate Veterans' Affairs Committee, the Maine Veterans Home thanks you for this privilege to express support of S. 1536, a technical amendment to title 38 of the United States Code.

More than 20 years ago, in 1964, the 88th Congress passed the State Veterans Home Construction Grant Program, a sharing by Federal and State governments of both construction and operational costs of State veterans homes. Shortly thereafter, the 89th Congress passed the Medicare-Medicaid Program, the Medicaid portion of which is another Federal-State Cost Sharing Program which today is the primary source for funding the operational costs of nursing homes in this country.

These two acts of Congress come in conflict with one another when a State veterans home, such as the Maine Veterans Home, elects to become a certified Medicaid nursing home. One law provides through the Veterans' Administration a per diem of $17.05 for each day an eligible veteran receives care in a nursing home unit of a State veterans home.

The other law has been interpreted by the general counsel of HCFA to the effect that the VA per diem is used to replace Federal and State Medicaid dollars financing nursing home units of State veterans homes certified in the Medicaid programs. Thus, in such circumstances the VA per diem does not benefit the veteran. Instead, the VA appropriation merely replaces the Federal and State share in the cost of the Medicaid Program. The general counsel's decision results in a unique form of Federal revenue sharing, without benefit to the veteran.

The Maine Veterans Home does not believe that the result described above was the intend of Congress, either in the legislation creating the VA per diem or in the Medicaid third-party liability statutes.

The Maine Veterans Home believes that Congress clearly intended the VA per diem to be used for the benefit of veterans in State veterans homes. The conflict arises when the HCFA general counsel States that Medicaid regulations define a third party as "any individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease, or liability of an applicant or recipient." The Maine Veterans Home believes that this Medicaid statute was directed at collecting private or group health insurance, workers' compensation or liability claims on behalf of a Medicaid client, before using Medicaid dollars.

The Maine Veterans Home does not believe that it was the intent of Congress to use the VA per diem as first dollar payment in supporting the worthwhile concept that the Medicaid Program should be the payer of last resort.

Favorable consideration of S. 1536 by this committee and the 99th Congress will result in directing the VA per diem to benefit the veteran, rather than replacing Federal-State Medicaid dollars. If this proposed amendment is enacted States would no longer be able to replace State tax dollars with the VA per diem and would be required to meet the State share of the Federal-State Medicaid Program with State appropriations, rather than in part, with the VA per diem.

In this fiscal year, the Maine Veterans Home will receive approximately $450,000 in VA per diem on behalf of Medicaid eligible veterans. The Federal-State Medicaid sharing in Maine is approximately two-third Federal to one-third State. Under the current ruling by HCFA, the State takes the $450,000, uses one-third, $150,000, to replace the State share of the Medicaid Program, and uses the other two-thirds, $300,000, to offset the Federal share of the Medicaid payment.

From a common sense point of view, it does not seem prudent to appropriate funds to one Federal agency, the Veterans' Administration, for the purpose of providing a benefit to veterans, merely to have such funds used to replace Federal and State funds in another program, Medicaid, without any benefit to the veteran for whom the funds were originally intended.

Medicaid eligible veterans at the Maine Veterans Home are entitled to Medicaid benefits, even if the home was not in existence. Therefore, it seems reasonable that the VA per diem be used to further enhance the quality of care available to the veteran, and not merely subsidize both the Federal and State share of the Medicaid Program.

Passage of this legislation will allow States such as Maine, and other States who are considering the initial construction of State veterans' nursing homes an opportunity for financing the capital and operational costs of such homes which will provide a higher quality of care for the Medicaid eligible veterans than that provided at any other Medicaid funded nursing home. The combination of VA per diem and Medicaid financing in the long run is the least costly means by which Federal and State governments can meet the long-term care institutional needs of our aging veteran population. Attachment 1 to my comments lists some advantages of enactment of S. 1536.

Thank you, Mr. Chairman and Senator Mitchell, for your consideration of these comments.

[The prepared statement of Mr. Carney appears on p. 95.]

Senator MITCHELL. Thank you, Mr. Carney.

Am I correct that Maine is one of only four States that funded State homes through the Medicaid Program?

Mr. CARNEY. To the best of my knowledge only the States of New York, Wisconsin, Colorado, and Maine currently use the Medicaid Program as a part financial mechanism.

Senator MITCHELL. Do you believe that if S. 1536 were enacted it would lead to a wholesale changeover in the way State homes are financed?

Mr. CARNEY. No; I do not believe that that would happen, Senator, because I think S. 1536, if enacted, will primarily help those States such as Maine that are less economically advantaged than other States. A measurement of economic advantage of the States is the Medical Federal-State matching ratio. Those States that have a higher Federal to State matching ratio in the Medicaid Program will benefit most by enactment of S. 1536.

The other fact in this, I think, is that it will primarily help States that are today thinking about a new home or recently had a new home constructed, rather than the traditional States that have funded their operations through State general fund appropriations.

Senator MITCHELL. Now, Maine has recently enacted legislation authorizing the construction of two additional State veterans homes. How would the enactment of S. 1536 affect Maine and other States that are considering the authorization or the construction of State homes?

Mr. CARNEY. The 180 beds authorized in April by the Maine Legislature consists of 120 beds in southern Maine, which are on the lists of proposed construction grants held by the Veterans' Administration. It will be 5 years before that 120-bed facility is constructed at the present level of funding of that list. On the other hand, in northern Maine we are talking about up to 60 beds in size.

Passage of S. 1536 would allow the State of Maine to use conventional financing for the capital construction costs of a small home, 60 beds and under, in Aroostook County. Thus, we would not have to get on the construction list, we would be able to finance a bed that would meet the VA operational standards, the costs to the Veterans' Administration would be only operational costs, $17.05 a day.

Senator MITCHELL. In its written testimony, the VA indicated that enactment of S. 1536 would, in its view, tend to be contrary to congressional intent that the per diem program operate as a shared Federal-State undertaking. Do you agree with the VA on that point?

Mr. CARNEY. I believe in the concept of the Federal-State sharing of the construction grant program. I think if you analyze my testimony you will see that the per diem is now used to reduce the State share. So that passage of S. 1536 would increase the State share.

Senator **Mitchell**. Well, then that leads to my next question. Under the present arrangement who benefits, the veteran? the home? the VA? or the State?

Mr. **Carney**. Well, Senator, the veteran does not benefit because the per diem goes to replace State and Federal Medicaid dollars. The home does not benefit because of the—for the same reason.

The Veterans' Administration fulfills its statutory responsibility by providing the home with the $17.05.

The State and the Federal Medicaid Program both benefit by the present arrangement because the per diem is used to offset State and Federal Medicaid payments.

Senator **Mitchell**. And if S. 1536 were passed, where would the benefit vest?

Mr. **Carney**. Well, primarily the veteran would benefit because the veterans' home would be able to retain the VA per diem for use of the veteran. And I think that is what Congress originally intended.

Senator **Mitchell**. Thank you very much, Mr. Carney. That was very effective testimony and we appreciate it.

And in behalf of the committee I might say that we commend you for the excellent and innovative program implemented at the Maine Veterans Home. I am personally familiar with it, having visited there on several occasions, and I believe it is an outstanding example of what can be done with innovation, hard work, and a commitment to meet the needs of our veterans. And we do appreciate that.

Mr. **Carney**. Thank you very much.

Senator **Mitchell**. I apologize to the members of the next panel. I have to leave to go to another meeting. But I and the other members of the committee will review the testimony in connection with this and other pending legislation.

Thank you, Mr. Carney.

Mr. **Carney**. Thank you, Senator.

Mr. **Principi** [presiding]. Thank you, Mr. Carney.

At this time I would like to call Mr. Paul Egan and Mr. John F. Sommer, The American Legion; Mr. Dennis Cullinan, the VFW; Mr. David Gorman, DAV; Col. David J. Passamaneck, AMVETS; and Mr. Bob Moran of the Paralyzed Veterans of America.

Mr. Egan, Mr. Sommer, you may begin.

## STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. **Egan**. Thank you, Mr. Principi.

I will address two issues under consideration at today's hearing and John Sommer will summarize the balance of our statement.

First of all, section 201 of S. 2422, regarding the Home Loan Program, would prohibit the acquisition of foreclosed properties by VA unless the Administrator determined the disposal of the property could be achieved within 1 year and unless that disposal could be accomplished in a manner advantageous to the Government.

We are obviously sympathetic to the problem of VA's large inventory of foreclosed properties, and certainly sympathetic to the desire to reduce that number in the future. However, we are constrained from supporting that provision in the absence of three specific assurances. And those are that lenders will continue to deal with veterans in spite of the fact that VA would not be permitted to acquire properties;

Second, that OMB would not be tempted to use this change in the laws to prevent VA from acquiring any properties irrespective of marketability;

And, finally, we have some question about whether or not VA currently has sufficient numbers of personnel to carry out whatever might be necessary to advise the Administrator as to whether or not a property was marketable within 1 year and whether it could be marketed to the advantage of the Government.

And in that regard I would note, or I would ask the committee to note, that just since January of this year the VA Home Loan Program has lost some 25 percent of its home loan personnel. That being the case, augmenting its already heavy responsibilities might not be a good idea.

On the other hand, the housing legislation approved by this committee and the Senate last year contained a different approach to the disposition of foreclosed properties. That was to contract out on a pilot basis to see whether or not that would solve the problem. Given the shortage of personnel and the temptations that this proposal might hold for OMB and the question mark about lender response to this change, last year's approach probably would be a preferable approach.

The other matter that I will briefly discuss is Senator Cranston's legislation, S. 2304, which would extend the Veterans' Readjustment Appointment Authority Program. We fully support that legislation, but make one further suggestion. And that is that the limitation on the number of years of education that a veteran can have in order to participate be relaxed.

We think this can be done without compromising the readjustment nature of this program. If, for example, no veteran with more than 16 years of education were permitted to participate, we think that would be appropriate.

In hearings before the House Subcommittee on Education, Training, and Employment, representatives of the Department of Education and HHS both testified when asked why VA seems to be the only major agency to use this program, that the employment structure of their agencies happened to be skewed toward more highly educated individuals.

I think, with that in mind, many more veterans could participate in Federal employment under this program if that educational limitation were relaxed.

Mr. **Principi**. Mr. Sommer.

## STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. **Sommer**. Thank you, Mr. Chairman.

Because of the number of issues under consideration today, we will just touch on a brief number of them. And, of course, the remainder are addressed fully in our statement.

The American Legion supports increases in compensation and related benefits that are consistent with increases in the consumer price index.

We urge the enactment of a measure encompassing the intent of S. 2186, S. 2187, and S. 2423, to exempt several important veterans' benefits and revolving funds from further sequestration under Gramm-Rudman.

We also feel very strongly that the Educational Assistance Program under chapter 34 should be included among these programs.

In addition to the direct benefits that have been addressed in this legislation, the American Legion is very much concerned about the effects of Gramm-Rudman and budget proposals on the operations of the Department of Veterans' Benefits, which has lost almost 5,500 FTEE since fiscal year 1979. Based on information that we are receiving from our department service officers, the combination of the personnel losses, early retirements and the hiring freeze are causing innumerable problems in all of the regional offices. And we anticipate an immediate deterioration in the quality and timeliness of the delivery of benefits and services to veterans unless something is done to remedy this situation.

We support the enactment of S. 2168 to further improve benefits for our former prisoners of war.

The American Legion favors the enactment of section 6 of S. 2388, to provide readjustment counseling to current members of the Armed Forces who served in Vietnam and to those who served after the Vietnam war and were involved in situations such as the United States Marine Corps in Beirut and the joint services personnel that were involved in the invasion of Grenada.

We strongly urge the extension of the authorization of appropriations for construction grants to the State homes as set forth in section 12 of S. 2388. The Legion is very much in favor of making respite care a permanent program, as would be accomplished with the enactment of section 2 of S. 2445. We consider respite care one of the innovative treatment techniques and modalities that can make the Veterans' Administration medical care system more cost effective and able to care for the largest number of patients.

This program, of course, allows veterans to remain in their homes and communities rather than being institutionalized, thus enhancing the quality of life that is provided these patients.

Following that philosophy, we also support section 3 of S. 2445, to authorize VA to furnish hospital-based home care and health-related services to certain veterans in their homes.

Mr. Chairman, that completes our summary.

Mr. Principi. Thank you, Mr. Sommer.

[The prepared statement of Mr. Egan and Mr. Sommer appears on p. 100.]

Mr. Principi. Mr. Cullinan.

## STATEMENT OF DENNIS M. CULLINAN, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Thank you for this opportunity to present the views of the Veterans of Foreign Wars of the United States with respect to the various pieces of legislation affecting veterans' benefits and compensation.

In view of the large array of legislative proposals under consideration today I will just present a brief and partial overview of our written statement.

The VFW strongly supports S. 2168, to include organic residuals of frostbite and arthritis resulting from trauma to the list of presumptive disabilities for former prisoners of war.

We support S. 2186, which would exempt any amounts available to provide certain benefits to veterans with service-connected disabilities from sequestration under the Balanced Budget and Emergency Deficit Control Act of 1985.

VFW also supports a similar measure, S. 2187, which would exempt from sequestration certain benefits for veterans and dependents and survivors of veterans which are based on service-connected disability or death.

The VFW supports the enactment into law of S. 2304, which would extend the period during which veterans' readjustment appointments may be made to 1989.

The VFW is generally supportive of one of the more extensive bills under consideration today, S. 2422. This measure provides for a 3.4-percent increase in the rates of disability compensation and DIC, and numerous other provisions. The VFW, however, is adamantly opposed to the language we reviewed in the draft version of this measure cited as section 301, Administrative Debt Collection by Offset of Benefits. It is our understanding that this subsection would allow the Administrator to collect by offset of compensation or pension payable to a veteran by the VA, the uncollected portion of retired or retainer pay for service in the Armed Forces.

We are incredulous that this otherwise meritorious measure could contain language which would allow for the garnishment of service-connected disability compensation. To deprive a veteran of any part of the compensation he has earned at the price of his blood is bad enough, but when one also takes into consideration that this could establish the precedent for the wholesale garnishment of VA compensation and pension, it is absolutely unacceptable.

The next measure we will address is S. 2423. The VFW views favorably this legislative proposal to provide veterans additional protection from reductions under Gramm-Rudman-Hollings. As with S. 2187, we favorably note the language contained in this measure, which would prohibit the protection from resulting in larger reductions in the accounts to which the protected benefits belong.

At this juncture we will now address legislation pertaining to veterans' health care.

The VFW is in basic agreement with the majority of the provisions contained in S. 2445, Veterans' Health Care Program Improvement Act of 1986. However, we are absolutely opposed to the misguided proposal contained in section 6, to include domiciliary beds in the number of beds which the Administrator must operate and maintain for the care and treatment of veterans and as a contingency component to assist DOD in time of war or national emergency.

It is clearly not the intent of the law to lump domiciliary beds together with hospital and nursing home beds. Hospital and nursing home beds are labor and medical intensive units exclusively suited to provide the highest level of medical care necessary when caring for severely injured and disabled.

In contradistinction, domiciliary care is merely a program offering shelter, subsistence, and continuing rehabilitative medical care on an ambulatory, self-care basis. It is readily apparent these domiciliary beds are absolutely unsuited for the provision of anything but the lowest level of medical care to those who are essentially already able to care for themselves.

The VFW supports S. 2174, inasmuch as it would provide for the nondiscriminatory treatment of veterans in need of health care by the private sector.

The VFW supports S. 2388, which is to improve the various aspects of the VA's health care programs. We would make special mention of section 3, "Services To Overcome Service-Connected Disability Affecting Procreation," and section 7, "Respite Care Pilot Program." We feel that they are long overdue.

The VFW strongly supports the final bill to be addressed at this hearing, S. 1536. This bill would provide that per diem subsidies paid by the VA for the care of veterans in State homes shall not be used to offset payments that are made under the Medicaid Program for the purpose of assisting eligible veterans.

It is clear to us that the VA per diem should not be considered a resource of an individual veteran because the VA makes the payment to the home, not the individual. It simply does not make any sense for the Congress to authorize the VA to make payments to State veterans' homes on behalf of veterans only for those funds to be used by State agencies to replace State and Federal Medicaid dollars with no benefit to the veteran.

It is our belief that the enactment of S. 1536 will be an important step toward ensuring State veterans' nursing homes are able to provide the level of care to veterans that Congress intended when it wrote the relevant laws.

Thank you, Mr. Chairman. This concludes my statement.

Mr. PRINCIPI. Thank you, Mr. Cullinan.

Mr. Gorman.

[The prepared statement of Mr. Cullinan appears on p. 137.]

## STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Principi. I also will attempt to summarize my statement, only with reference to those issues of particular interest, or concern to the DAV.

We certainly support the provisions of S. 2422 calling for a 3.4-percent increase in compensation, DIC, dependency allowances, as well as the clothing allowance. We would request, however, that the statutory award "K" also be included in this proposed increase.

Mr. Principi, I want to make one thing clear, and that is, for the well-being of the national economy, should the Congress elect to postpone, or defer any such cost-of-living adjustment in compensation benefits, the DAV will not necessarily object, so long as all Federal benefit or entitlement programs are dealt with in a similar fashion.

We do not support the amendment to section 3101 of title 38.

With one exception we have no objection to the proposed amendment to section 5009, dealing with parking facilities, the exception being we do not feel that parking fees should be charged to individuals who, visit a medical center for the purpose of visiting hospitalized veterans.

Mr. Principi, DAV supports both S. 2186 and S. 2187, proposing to protect certain VA benefits, from any future sequestration provisions, or orders under Public Law 99-177. We prefer, however, the provisions of S. 2187, which would encompass all participants in the vocational rehabilitation program.

Along the same lines we support and applaud Senator DeConcini's draft bill that proposes to exempt certain VA benefits from any future sequestration orders, unless such programs are specifically included in such orders, and Congress specifically states its intention to include those programs.

Mr. Principi, the DAV also strongly supports S. 2168, that would include the residuals of frostbite and traumatic arthritis in the list of diseases, and conditions, that would be presumed to be service-connected, in the case of former prisoners of war.

We have one final comment regarding the VA's disability programs, and that is the principle, that we have discussed previously before this committee, of paired organ involvement for those veterans who, are service-connected for the loss, or loss of use of one extremity, and who subsequently incur the loss, or loss of use of the remaining paired extremity.

We would request that any action this committee may take, to report a compensation increase bill to the full Senate, would include an amendment to section 360 of title 38 to include this paired extremity concept. In our view, this request is both meritorious and modest, considering that the VA estimates that only 64 such severely disabled veterans would be affected. It should also be noted that the majority of these 64 veterans are service-connected combat-disabled veterans.

With respect to the health care legislation, we would register our opposition to section 6 of S. 2445, proposing to alter the methodology the VA utilizes, to calculate the minimum number of beds that they are charged, to operate and maintain. Mr. Principi, this proposal in our view, serves only as a ready mechanism to bring the VA into compliance with the law, and neglects the real question of operating a sufficient number of acute, and long-term care beds within the system.

We have no official position with reference to section 3 of S. 2388. We would encourage, however, the committee to address the concerns we have mentioned in our written statement, regarding the nature and the scope of services to be offered, as well as the potential liability of the agency should they be required to provide such services.

We have no objection to enactment of section 9 of S. 2388, which would, as we understand it, limit the Administrator's discretionary authority to prescribe rules and regulations governing the provisions of furnishing VA health care. As a matter of fact, if we understand that provision correctly, we could certainly support the enactment of that provision.

Both S. 2445 and S. 2388 propose certain changes in the State extended care facilities construction grant program. We certainly endorse the extension of this program. We do not, however, find any compelling circumstances at this time that would prompt us to support any major changes in an established, and apparently effective program, that has otherwise funded projects in an equitable and appropriate fashion.

We favor those provisions of both S. 2445 and S. 2388, proposing to grant the VA authority to provide respite care to certain defined eligible veterans.

The DAV also supports the provisions of S. 2445 and S. 2338, granting the VA authority to furnish certain non-medical services to eligible veterans, in an attempt to obviate the need for hospitalization or nursing home care. We would request, however, that our thoughts regarding the type and array of services to be included be carefully considered, along with the use of geriatric evaluation units, in any program that may be initiated.

Mr. Principi, for the reasons described in our written statement we oppose the enactment of S. 2174. Finally, we support the intent and the provisions as outlined in S. 1536.

That will conclude my summation, Mr. Principi.

Mr. PRINCIPI. Thank you, Mr. Gorman.

Colonel Passamaneck.

[The prepared statement of Mr. Gorman appears on p. 151.]

## STATEMENT OF LT. COL. DAVID J. PASSAMANECK, U.S. ARMY (RET.), NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Colonel PASSAMANECK. Thank you, Mr. Chief Counsel.

At the outset, AMVETS is pleased to support S. 1536, which will prevent the erosion of certain state veterans 'home per diem payments in favor of the Medicaid Program.

We enthusiastically support all legislation the purpose of which is to preserve the true value of disability compensation in the face of continuing, although diminishing inflation. We particularly appreciate the exemption of these unique entitlements from the indiscriminate Gramm-Rudman cuts. It is terribly unfortunate that the Armed Services Committees of both Houses of Congress could not have thus far shown the same consideration for our military careerists, whose COLA was the first sacrifice on the Gramm-Rudman chopping block.

We believe that the increase should be no more and no less than the actual increase in cost of living. And we are opposed to artificial increases above the actual cost of living increase, for Social Security or VA compensation. We must remember that the exemption of compensation from Gramm-Rudman imposes a proportionately greater burden on the medical and administrative portions of the VA budget. We know the sad condition of those elements, and we do not see—we do not want to see unnecessary and unjustified increases eating further into their diminished resources.

AMVETS supports the debt collection amendments set forth in the draft legislation. However, as we have for many years, we urge the enactment of legislation exempting military longevity retired and retainer pay from offset by VA compensation. There is absolutely no justification for denying military retirees the incremental benefit of earned VA compensation because they have also earned retired pay through dedicated career service in the military.

Regarding the proposals for the provision of respite care as set forth in S. 2445, introduced by the chairman, and S. 2388, introduced by Senator Cranston, AMVETS generally agrees with the need for such a program, both from the point of view of cost effectiveness and compassion.

We endorse the concept, but offer the caveat that these suggested programs in no sense give leverage to those who would curtail or further impair the provision of adequate hospital, nursing, home and domiciliary care. To ensure that the respite care alternative not have a deleterious effect on hospital, nursing and domiciliary care, the veteran should be given an ultimate option of choice between nursing, domiciliary, and respite care, where all forms are available. Veterans should not be turned away from nursing homes and domiciliaries involuntarily, if they require the degree of attention which would justify respite care.

We also endorse section 8 of S. 2388, for pilot studies of alternatives to institutional medical care, as we previously endorsed section 9 of S. 6 and section 2 of S. 876, introduced by Senator Cranston and the chairman, respectively, and H.R. 505. We also support the provisions of S. 2445 for case management of chronically mentally ill veterans in contracted facilities, with the same caveat as applies to respite care.

The flexibility which section 7 of S. 2445 would provide in granting funds for State homes is a practical measure which would expedite construction as funds become available.

AMVETS has never put unquestioning faith in the efficacy of the arbitrary bed limits and minimal requirements of section 5010 of title 38. We are more interested in the adequate provision of care, rather than playing a numbers game which rarely results in actually affecting the quality of that care. As to whether or not the minimal requirement for operating beds include domiciliary beds, we would prefer to suspend judgment at this time.

We appreciate the introduction of S. 2304 to extend for 3 years the authority to make veterans readjustment appointments as set forth in section 2014(b) of title 38. We also concur with extending benefits for ex-POW's as provided in S. 2168.

The legislation introduced by the chairman, S. 2186, and Senator DeConcini, S. 2423, to exempt various VA programs from the impact of Gramm-Rudman are justified as providing a minimum standard of moral integrity. We advocate, however, complete exemption of all budget items relating to national defense, including the VA budget in its entirety. Let us try to save money on some of the 40 programs which the Senate, as of now, refuses to eliminate as requested by the President, before we chip away at veterans or our chances for survival.

The purpose of S. 2174 seems to be practical and justified. Certainly the DRG system should govern VA costs for the provision of medical care by non-Federal facilities on contract, and we can see no reason why we should not use the proportionately much greater Medicare constituency as a wedge to require private providers to afford the same terms as the VA. We understand that S. 2174 is not intended as a step toward merging the VA health care system with Medicare, or as a basis for undue expansion of the non-Federal contracting system to the detriment of the VA-operated system.

We appreciate the concern reflected in Senator Cranston's proposal to expand eligibility for readjustment and extend counseling service to bereaved survivors of veterans who had been receiving mental health services prior to their death. AMVETS would, however, open the eligibility for readjustment counseling to all combat veterans.

The time for special treatment of Vietnam veterans is or should be drawing to a close and we believe this service, which has certainly proven its worth, should be generally available.

Regarding bereavement counseling, we would reserve judgment, pending a more thorough appreciation of costs involved. This is no time to be significantly expanding costs at the possible expense of other programs or risking the credibility of the total structure of VA programs.

Thank you.

Mr. **Principi**. Thank you, Colonel.

Before proceeding to Mr. Moran, the committee has been joined by Senator Heinz of Pennsylvania.

Senator Heinz.

[The prepared statement of Colonel Passamaneck appears on p. 189.]

## STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator **Heinz**. Gentlemen, excuse me for interrupting you, Mr. Moran. I want to thank the acting chairman. I am sorry that the chairman has become ill, I gather, and is unable to attend.

I am going to just make a brief statement with respect to S. 2168, which is legislation Senator Thurmond and I introduced to improve benefits for former prisoners of war.

Let me say at the outset that this committee deserves recognition for the work it has done to assist these former servicemen. I do not need to detail the horrors that being a prisoner of war entails because there are members on this committee who know them far better than anyone else.

But our legislation is really straightforward and quite simple. Former prisoners of war who suffer from residual effects of frozen hands and feet or from arthritis induced by trauma would receive a presumption of service-connected injury. The reason that such a presumption is necessary is because our Nation's enemies, quite frankly, were not kind enough to supply us with their medical records when they released them from prisoners of war camps. And the bill that Senator Thurmond and I have introduced would compensate for this by allowing ex-prisoners of war to receive priority care in the VA medical system for the disabilities which are most common to them.

And without the presumption of service connection and without detailed medical records to back up a serviceman's claim to benefits the VA will not, as we all know, provide service-connected care and, thus, will not grant an ex-POW the priority that he deserves in the VA system.

I had the privilege of getting some firsthand information in my State. There was a physical therapy session for a number of veterans held in Avoca—Avoca, excuse me—is at the airport near Scranton in Pennsylvania. And I learned that a dozen of the 20 veterans present had failed to receive service-connected care in the VA. And each of those 12—and literally it was an even dozen—had been captured in the Battle of the Bulge, and they had been forced to march across Germany in the dead of winter.

The others present either had not been prisoners of war or had not suffered frostbite.

There are some thousands of our servicemen who were forced to march through the bitter cold of German or Korean winters, and were housed in inadequate shelters. Many suffered frostbite and continue to suffer from the residual effects of frozen hands and feet. One, Bill Marsicano of Easton, PA, is a rather typical example. He provides a reason why I think we need a bill like S. 2168. He suffered frostbitten feet in 1945. His condition remains painful to this day. But because he could not prove that his suffering was brought on by wartime service, Mr. Marsicano never received service-connected care for his injuries.

Many prisoners of war suffered physical abuse from our enemies. Years later this has caused crippling arthritis. Again, these veterans are unable to procure service-connected care for their injuries. They have no records which detail the abuse they took, nor did they realize in 1945, or at the conclusion of the Korean war in 1953, that their condition would lead to the disabilities they suffer today. So, consequently, they did not immediately request care and treatment and they have been closed out of the VA for these problems ever since.

There are about 85,000 living ex-prisoners of war. Granting service-connected status to those who did survive prolonged exposure to subzero temperatures or who were tortured and beaten by our enemies is really not asking very much. Only a handful of veterans who were incarcerated received service-connected care for their injuries. These men, upon repatriation to the United States, told the Army's medical authorities of their injuries at that time or they complained to the VA promptly. Those who did not realize that their injuries would lead to crippling disabilities in their later years are now closed out.

My understanding is that the total cost of S. 2168 is less than $1 million a year. It strikes me that this is a very modest cost and that it is the least we can do for these heroic Americans. And I hope this committee will move quickly to approve S. 2168.

Mr. PRINCIPI. Thank you, sir.

Senator HEINZ. Thank you.

Gentlemen, I appreciate your forbearance. Thank you very much.

Mr. PRINCIPI. Mr. Moran, you may continue.

## STATEMENT OF BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. MORAN. Thank you. Thank you, Mr. Principi, in allowing PVA the opportunity to testify here today. And, again, I will summarize from our testimony.

PVA supports S. 2422, the Veterans' Compensation and Benefits Improvements Act of 1986, which provides for a 3.4-percent increase in the rates of compensation paid to veterans for their service-connected disabilities and in the rates of dependency and indemnity compensation paid their survivors.

In regards to section 303 of S. 2422, PVA does not support pay parking at Veterans' Administration facilities for veterans. This is not to say that the concept of pay parking at VA facilities should not be explored. PVA recognizes the need to explore alternative methods of funding and agrees with the committee in examining the use of the revolving fund approach as a possible solution to this dilemma.

PVA also supports the intent of legislation S. 2186 and 2187, measures to exempt from any requirement from sequestration of appropriated funds amounts available to provide certain benefits to veterans with service-connected disabilities. Certain essential and critical benefits to the more catastrophically disabled veterans were reduced. PVA, as an organization, represents these veterans. These reductions should have not happened and must not happen again.

With regard to S. 2174, PVA believes that the accessibility to quality medical care is the right of all veterans, regardless of their geographic location. While we support that the majority of this care be maintained in VA facilities, we recognize the need to utilize non-VA facilities in certain instances.

PVA supports any measure deemed necessary to continue the provision of this essential service.

In keeping with our mutual goal of quality health care, PVA is pleased to endorse certain provisions of S. 2388, a bill introduced by Senator Cranston, and S. 2455, introduced by Chairman Murkowski, certain provisions of. PVA would like to thank both Senators for the inclusion of respite care in their respective bills. PVA has long been an advocate for the need of VA to provide this most necessary and important service to veterans, including PVA's members, our members who suffer from a chronic medical condition requiring continual and constant supervision and care.

Our major concern with the respite care provisions in both bills is the requirement that the respite care be furnished in a VA hospital or nursing home. Most individuals with chronic conditions can and do live outside the permanent confines of a hospital or nursing home setting. PVA promotes the concept of its members obtaining and maintaining optimum levels of independence afforded by living in the community. The simple provision of an opportunity for respite care can often mean the difference of a veteran having to choose between life within an institution or in the community at large.

PVA is particularly pleased to address Senator Cranston's provision for procreative services to overcome service-connected disabilities preventing pregnancy. All of PVA's members are veterans who have experienced spinal cord injury or dysfunction, and SCI can and often does lead in a residual loss of procreative ability as a secondary impairment from the primary injury. Consequently, we are concerned that in accordance with this provision that title 38 be amended to also include veterans whose procreative disability is a secondary and functional impairment resulting from a primary disability, as is common in spinal cord injury. We believe this to be a necessary and essential clarification.

PVA is also pleased to support Senator Cranston's provision for bereavement counseling for family members and significant others of the veteran. PVA's experience with long-term disabilities emphasizes the important roles these people fulfill in the lives of catastrophically disabled veterans and the significance of their emotional well-being.

PVA also supports the provision within the chairman's bill, S. 2445, which requires the VA to prioritize State home grants and the funding for such projects. We think the proposals being made should go far toward bringing the state home construction grant program into a more systematic and evaluative process based more upon the actual needs of a given State.

And this concludes my statement. And thank you again for allowing us to be here.

[The prepared statement of Mr. Moran appears on p. 197.]

Mr. **Principi**. Well, I thank you for taking the time to testify and for preparing your testimony. I regret the absence of the chairman and other members. However, I can assure you that we will carefully consider your testimony.

I would like to just ask you to stay for a moment. Senator Cranston is en route. Why do we not just take a 5-minute recess.

[Recess.]

## OPENING STATEMENT OF SENATOR CRANSTON

Senator **Cranston** [presiding]. I thank you very much. I thank you for holding the meeting.

I have a very short morning in Washington because of all sorts of commitments, but I want to say that I am pleased that I did get here this morning.

I thank all of the witnesses who are appearing before the committee at today's hearing for your willingness to share with the committee your views on the many bills that are before us today. I realize you have been asked to review and comment on some of these measures within very tight timeframes, which we all work under here frequently, and as I am today. Should you have additional views after you have had a longer time to review the legislation, we would, of course, be happy to hear from you in that regard.

I have a prepared statement that is available at the press table. I ask unanimous consent that it appear in the record of this hearing.

And not hearing any objection from any member of the committee, it is so ordered. [Laughter.]

[The prepared statement of Senator Cranston appears on p. 34.]

Senator **Cranston**. I do want to express personally my appreciation to the veterans' organizations for the support they have expressed for many aspects of the legislation that I have introduced, and to the VA for their generally constructive testimony, and for the administration's qualified support for most provisions of this legislation.

I regret that I was not able to be here earlier today, but we have had the advantage of having your testimony in advance.

I look forward to working with all of you in the weeks ahead as we develop legislation based on the measures which are pending before us today.

I again thank each and all of you for your cooperation and your assistance.

And with that, the hearing is adjourned.

[Whereupon, at 11:05 a.m., the committee was adjourned.]

# APPENDIX

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## OPENING STATEMENT OF SENATOR FRANK H. MURKOWSKI, CHAIRMAN BEFORE A HEARING OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS CONCERNING CERTAIN HEALTH-CARE, COMPENSATION, AND OTHER BENEFITS LEGISLATION, MAY 20, 1986

Good morning. Welcome to the Veterans' Affairs Committee hearing on proposed legislation concerning Veterans' Administration health-care, compensation, and other benefits programs. We want to welcome the witnesses who will appear before us today including Dr. John Ditzler, the VA's Chief Medical Director and representatives of the veterans' service organizations.

We have quite a variety of bills and issues on the Committee's agenda today. We will receive testimony today on a number of bills relating to veterans' health care including: S. 2445, the proposed "Veterans' Health Care Programs Improvements Act of 1986", which I introduced last week. In addition, the Committee will consider S. 2422, a bill introduced by myself, Senator Cranston and Thurmond relating to compensation for veterans' with service-connected disabilities. Other bills relating to compensation and other benefits programs will also be considered.

The Committee continues to be concerned about the VA's ability to address the changing needs of our veteran

POPULATION. AN INCREASED NUMBER OF ELDERLY CITIZENS ARE BEING TREATED IN NONINSTITUTIONAL SETTINGS. THESE METHODS ARE SURELY THE MOST HUMANE AND COST-EFFECTIVE METHODS OF TREATMENT. A PROVISION OF MY BILL, S. 2445, WOULD ENCOURAGE THE VA TO EXPAND ITS USE OF THESE ALTERNATIVES BY PROVIDING THEM WITH THE FLEXIBILITY THEY NEED TO USE THESE TREATMENT METHODS. S. 2445 WOULD PROVIDE THE VA WITH THE ABILITY TO FURNISH RESPITE CARE TO SEVERELY DISABLED VETERANS WHO RESIDE PRIMARILY IN THE HOME. IN ADDITION, THIS BILL WOULD GIVE THE VA THE AUTHORITY TO CONTRACT FOR HOSPITAL-BASED HOME CARE WHICH THE VA CURRENTLY PROVIDES TO CERTAIN CHRONICALLY ILL VETERANS. AND THE VA WILL ALSO HAVE THE AUTHORITY TO CONTRACT FOR HEALTH-RELATED SERVICES WHICH CAN BE PROVIDED TO VETERANS IN LIEU OF HOSPITAL, NURSING HOME OR DOMICILIARY CARE. THIS PROVISION WOULD ALLOW THE VA TO CONTRACT FOR HOMEMAKER, TRANSPORTATION, NUTRITION, AND OTHER PERSONAL CARE SERVICES. MY BILL WOULD ALSO CLARIFY THE VA'S AUTHORITY TO CONTRACT FOR PSYCHIATRIC RESIDENTIAL TREATMENT IN HALFWAY HOUSES AND OTHER COMMUNITY-BASED FACILITIES FOR THE CARE OF THE CHRONICALLY MENTALLY ILL. A SIMILAR PROVISION WAS INCLUDED IN S. 876, WHICH I INTRODUCED, AND WAS PASSED BY THE SENATE. HOWEVER, THE HOUSE DID NOT ACCEPT IT IN CONFERENCE.

S. 2445 WOULD REDEFINE THE LAW WHICH REQUIRES THE VA TO OPERATE 90,000 HOSPITAL AND NURSING HOME CARE BEDS. MY PROVISION WOULD ALLOW THE VA TO COUNT THEIR 7,000 DOMICILIARY BEDS FOR THE PURPOSES OF THE 90,000 BED REQUIREMENT. I HAVE BEEN TOLD THAT THIS 90,000 BED REQUIREMENT UNNECESSARILY

RESTRICTS HOSPITAL DIRECTORS BY LIMITING THEIR CAPABILITY TO USE ALTERNATIVES TO INSTITUTIONAL CARE AND OTHER MORE EFFECTIVE AND HUMANE TREATMENT MODALITIES WHEN APPROPRIATE. IN ADDITION, DURING THE COMMITTEE'S APRIL 10 HEARING ON VA MEDICAL FACILITY CONSTRUCTION, VA ADMINISTRATOR TOM TURNAGE STATED THAT THEIR ABILITY TO COUNT DOMICILIARY BEDS WOULD PROVIDE THEM WITH THE INCREASED FLEXIBILITY NEEDED TO ADAPT TO CHANGES IN MEDICAL TECHNOLOGY AND TREATMENT MODALITIES. THIS PROVISION IS NOT DESIGNED TO SHRINK THE VA'S COMPREHENSIVE MEDICAL CARE SYSTEM.

PARKING AT VA MEDICAL CENTERS IS ANOTHER PROBLEM WHICH, IF UNADDRESSED, COULD REDUCE THE EFFECTIVENESS OF THE CARE WE PROVIDE VETERANS. WE FIND OURSELVES IN A SITUATION WHERE, IF WE ARE TO HAVE ADEQUATE PARKING FACILITIES, WE ARE GOING TOHAVE TO INSTITUTE A REASONABLE PAID PARKING POLICY. THERE ARE SIMPLY INSUFFICIENT DOLLARS AVAILABLE TO CONSTRUCT THE NEEDED PARKING FACILITIES. I THANK MY COLLEAGUE, THE DISTINGUISHED RANKING MINORITY MEMBER, FOR JOINING WITH ME IN THIS EFFORT AND COMMIT TO HIM THAT A SAN FRANCISCO GARAGE IS THE HIGHEST PRIORITY IN THIS REGARD.

S. 2422 WOULD ESTABLISH A REVOLVING FUND TO PAY FOR NEW PARKING STRUCTURES AND WOULD REQUIRE A REASONABLE CHARGE IN CASES WHERE NEW PARKING FACILITIES ARE BUILT THAT COST MORE THAN $500,000. I EMPHASIZE THIS CHARGE WOULD NOT BE PAID BY VETERAN PATIENTS. IT WOULD BE PAID BY STAFF, VISITORS, AND

OTHERS. IN THIS WAY WE CAN AFFORD TO BUILD NEEDED PARKING FACILITIES THAT OTHERWISE WOULD NOT BE CONSTRUCTED.

IN ADDITION, S. 2422 WOULD PROVIDE A COST-OF-LIVING ADJUSTMENT FOR SERVICE-CONNECTED VETERANS. THE SENATE RECENTLY ADOPTED A BUDGET RESOLUTION FOR FISCAL YEAR 1987. I AM PLEASED THAT VETERANS FARED VERY WELL IN THIS RESOLUTION. IT PROVIDES FOR FULL COST-OF-LIVING INCREASES FOR VETERANS' COMPENSATION AND PENSION AND CONTINUES MEDICAL CARE AT THE CURRENT SERVICES LEVEL. SINCE THIS BUDGET RESOLUTION MEETS THE GRAMM-RUDMAN-HOLLINGS DEFICIT REDUCTION TARGETS, THERE WILL BE NO FY 87 SEQUESTER IF IT BECOMES LAW.

S. 2174 CONCERNING MEDICARE FEE SCHEDULES IS A MEASURE PROPOSED LAST YEAR BY THE ADMINISTRATION. THIS PROPOSAL WOULD REQUIRE THAT PRIVATE SECTOR PROVIDERS USE THE SAME FEE SCHEDULES REQUIRED BY MEDICARE WHEN BILLING THE VA FOR PRIVATE SECTOR SERVICES PROVIDE TO VETERANS. I INTRODUCED THIS MEASURE AT THE REQUEST OF THE ADMINISTRATION. I BELIEVE IT MAKES SOUND ECONOMIC SENSE BY REQUIRING UNIFORMITY IN MEDICARE AND VA REIMBURSEMENT PRACTICES. I DO QUESTION WHAT IMPLICATIONS IT MAY HAVE FOR PHYSICIANS' WILLINGNESS TO CARE FOR VETERANS, PARTICULARLY IN ALASKA WHERE HEALTH CARE COST ARE GENERALLY HIGHER THAN IN THE LOWER 48 STATES.

THERE ARE MANY OTHER IMPORTANT PROVISIONS TO BE CONSIDERED TODAY. I LOOK FORWARD TO HEARING TESTIMONY ON ALL

OF THEM, ESPECIALLY THE VIEWS ON MY LOAN GUARANTEE PROPOSAL CONTAINED IN S. 2422 AS WELL AS THE BILLS WHICH WOULD PROVIDE EXEMPTIONS FROM ANY SEQUESTRATION UNDER GRAMM-RUDMAN FOR CERTAIN PROGRAMS FOR SERVICE-CONNECTED VETERANS.

AGAIN, I WELCOME TODAY'S WITNESSES AND LOOK FORWARD TO YOUR TESTIMONY. I NOW RECOGNIZE MY COLLEAGUE, THE DISTINGUISHED SENATOR FROM CALIFORNIA, ALAN CRANSTON FOR HIS OPENING STATEMENT.

OPENING STATEMENT
SENATOR ALAN CRANSTON
RANKING MINORITY MEMBER
COMMITTEE ON VETERANS' AFFAIRS

## LEGISLATIVE HEARING ON VARIOUS BILLS RELATING TO VETERANS' HEALTH CARE, COMPENSATION, AND OTHER BENEFIT PROGRAMS

MAY 20, 1986

Thank you, Mr. Chairman. I am pleased to welcome all of those present to this hearing to consider various legislative items relating to Veterans' Administration health care and compensation programs. We are very grateful to those of you who are appearing before us today for providing us with your views on the pending legislation.

At the outset, I wish to note that in light of the great need to reduce the towering federal deficit, it is incumbent upon those of us in Congress to exercise prudence and restraint as we consider legislation relating to federal programs of benefits and services. Having said that, however, I want to note what I hope is clear to all here today -- namely, my unswerving commitment to the maintenance of a strong and vital program of benefits and services for those who answered the Nation's call in its hours of need and the survivors of those who made the ultimate sacrifice. Veterans' benefits and services are a fundamental component of our national defense effort and must be so regarded.

That does not mean that the VA can be unaffected as we move ahead with Government-wide efforts to reduce the deficit. Nor do I believe anyone here today advocates that position. At the same time, I do not believe that we can halt all efforts to update and improve VA programs. Outdated, ineffective, or unnecessary programs can and should be eliminated. Likewise, needed initiatives -- particularly those which respond to the changing demographics of the veteran population and for advances in health care and rehabilitation -- can and should be taken. The system must not become static.

I intend to keep this perspective in mind as we move forward with the legislation that is before the Committee today.

As the author of S. 2304, introduced on April 15, and S. 2388, introduced on April 30, I will, of course, be very interested in the witnesses' views on those measures, as well as on the many other bills scheduled for today's hearing.

I ask unanimous consent that the text of S. 2304 and S. 2388 and my floor statements describing these two measures appear in the hearing record at an appropriate place.

### S. 2388

With more specific reference to S. 2388, because the various elements of that bill are described in detail in the floor statement, I would like, at this point, just to highlight certain of its provisions.

Respite Care Pilot Program: First, section 7 would authorize the VA to carry out a 3-year pilot program of respite care under which the VA would periodically provide -- for short periods of time -- a hospital or nursing home bed to a veteran with a compensable service-connected disability who is otherwise receiving care at home. The ultimate goal of respite care, which is a relatively new form of care, is to help maintain an individual in his or her home as long as possible before having to resort to institutional care. It is widely agreed at this point that, where medically feasible, maintaining a person at home is not only better for the person's overall health status, but is also a far more efficient and cost-effective way to meet the individual's health-care needs. The theory of respite care is that, by providing scheduled relief for the primary caregiver -- who is most often the spouse or child of the person who is receiving care -- it will be possible to maintain the person in need of care at home for a longer period of time. I believe that the VA should be given authority to carry out an appropriate pilot program to evaluate the medical efficacy of providing respite care within the VA and of the impact of any such effort -- without detracting from the care it is required, under the recently enacted Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, to furnish to veterans needing that care.

Non-Institutional Care Pilot Program: Second, section 8 would require the Administrator to conduct through 15 demonstration projects a 6-year pilot program under which veterans eligible for and otherwise in need of VA institutional care would instead receive care, including health-related services from non-VA entities, in non-institutional settings. Through this pilot program, the VA would provide certain veterans with medical, rehabilitative, and other health services and, by contract with non-VA entities, with health-related services.

These health and health-related services would be provided in noninstitutional settings -- such as the veteran's home or a board-and-care home -- with the goal of avoiding institutional care, such as in a hospital, nursing home, or domiciliary facility, for the participants in the program. Participation in the program would be limited to veterans eligible for and otherwise in need of VA hospital, nursing home, or domiciliary care, and priority for care and services through the pilot program would be accorded to veterans with service-connected disabilities, to veterans who are 65 or older, and to veterans who are totally and permanently disabled.

Section 8 is virtually identical to a provision reported by our Committee and passed by the Senate last year. Unfortunately, we were unable to reach agreement on that provision with our colleagues in the House, so the provision was not included in the measure which became Public Law 99-166. I reintroduced this provision this year because I remain convinced that, in light of current developments in health services which enable more individuals to receive needed care without being institutionalized and of the rapid increase in the number of veterans age 65 and older who may be seeking care from the VA in the years ahead, the VA must take steps to develop new approaches to addressing the health-care needs of veteran patients.

Bereavement Counseling: Third, in cases in which a veteran's family members have been receiving counseling or mental health services from the VA in connection with the veteran's care or counseling, section

4 would authorize the VA to provide bereavement counseling to these family members for up to 6 months following the veteran's death.

Under current law, the VA provides mental health counseling and certain other services to the family members of a veteran when doing so is necessary for the effective treatment of the veteran. This authority is relied on most often in connection with veterans receiving general mental health services, with veterans receiving readjustment counseling through the VA's Vet Center program, and with various VA programs which provide care to terminally ill veterans. All indications that I have received are that providing family counseling in cases like these has been of great importance in the agency's efforts to assist the veterans who are receiving care.

Unfortunately, under current law, family members lose their eligibility for further counseling at the time of the veteran's death, the very time when they may be in the greatest need of assistance from a professional who knew the veteran and is familiar with the family members' relationships with the veteran and who has established rapport and trust with them. To correct this situation so that family members can receive bereavement counseling from someone with whom they have already developed a supportive relationship, this section would authorize the VA, for up to six months following the veteran's death, to continue to furnish appropriate mental health services, in the form of bereavement counseling, to family members who were receiving it before the death of the veteran.

Extensions of Readjustment Counseling Eligibility: Fourth, section 6 would make two new groups of individuals -- Armed Forces active duty personnel who served during the Vietnam era and persons who served in the Armed Forces after the Vietnam era in combat-like situations -- eligible for readjustment counseling services from the VA. Under current law, eligibility for such services is limited to veterans of the Vietnam era.

Individuals who served during the Vietnam era but who are still on active duty -- and thus are not "veterans" under the applicable definition in section 101(2) of title 38, United States Code -- are not now eligible for readjustment counseling. Although I am not aware of any data suggesting a widespread unmet need for counseling among active-duty personnel who served in Vietnam, I continue to hear from individuals working in the VA's Vet Center program and also from such active-duty personnel directly about requests from active-duty personnel for such counseling. Indeed, I have been aware of efforts at some Vet Centers to provide services to active-duty personnel despite a lack of express authority to do so. I do not believe that any individual who served in the Armed Forces during the Vietnam era and feels a need for readjustment counseling should be barred from eligibility simply because he or she is still on active duty. This section of the bill would remove that bar.

The second change in eligibility for readjustment counseling that would be made by this section of the bill would be an expansion of the period of service that makes an individual eligible to include certain service after May 7, 1975, the end of the Vietnam era. Under this change, the Administrator, after consultation with the Secretary of Defense, would be authorized to specify that service during periods of time in specific locations in which U.S. Armed Forces were under hostile fire would be qualifying service for readjustment counseling purposes. This provision recognizes that members of our Armed Forces are at times exposed to situations short of declared war -- such as existed in Beirut or on Grenada or that exist today in connection with our actions against Libya or possibly Nicaragua -- that might produce the need for readjustment counseling.

Independent Living Services: Fifth, section 11 would make permanent the authority of the Administrator to conduct a program of independent living services and assistance for severely-disabled service-connected veterans for whom the VA determines the achievement of a vocational goal is not reasonably feasible.

This program has been carried out pursuant to provisions I authored in 1980 which authorized the VA to conduct such a program on a pilot basis for a period of 4 fiscal years, 1982 through 1985, to provide assistance to such veterans in order to enable them to achieve maximum independence in daily living. The Administrator was authorized thereunder to provide for the furnishing of services and assistance through contracts with public or nonprofit agencies, or through the facilities of the VA's Department of Medicine and Surgery, that have a demonstrated capacity to conduct independent living services programs for handicapped persons.

This program was modeled after the program of services and assistance provided under title VII, of which I was the principal author, along with former Senator Jennings Randolph, of the Rehabilitation Act of 1973, as added by the Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978, Public Law 95-602. Not more than 500 veterans a year were to be afforded an opportunity to initiate a program of independent living services. Experience under the pilot program demonstrates that the utilization of the program did not approach the magnitude originally envisioned but that, for those veterans who participated, the services and assistance provided were very beneficial.

Although the VA has failed to submit a final report -- which was due in September 1984 -- on the effectiveness of the program, the interim report which was submitted last August shows that the program can play an important role in the lives of certain severely disabled veterans in terms of assisting them to achieve maximum independence. Therefore, I believe that the authority for the Administrator to provide this type of service and assistance to such veterans should be made a permanent part of the VA's fabric of benefits.

Medical Services to Overcome Service-Connected Disabilities Impairing Procreative Ability: Sixth, section 3 would provide authority for the VA to furnish services to enable a male or female veteran or a male veteran's spouse to achieve pregnancy, for example through artificial insemination or *in vitro* fertilization, in cases in which a veteran's service-connected disability impairs procreative ability.

As a result of my work on behalf of a woman veteran who had a service-connected disability which prevented her from becoming pregnant, I became aware of the fact that the VA does not believe that it has legal authority under current law to provide services to help overcome such a disability. Although I do not believe that the VA's legal interpretation of its existing authority is correct, and I did my utmost to change that interpretation, I was not successful. Hence, I have proposed this provision in order to remove any doubts that may exist on this issue.

Because this authority would be limited to cases in which a veteran's service-connected condition is impairing procreative ability, it will be targeted on those veterans as to whom the VA has always had the greatest responsibility -- those disabled during their service.

Finally, with reference to S. 2388, I want to note, as I did in more detail in my introductory statement on this bill, that this legislation seeks to find ways to improve VA health-care programs, through the development of more effective and cost-efficient services, without incurring any significant new costs. In most of the instances of new VA health-care efforts which would be authorized under provisions in the bill, the VA should experience insignificant, if any, new costs. To the extent that relatively minor new costs would be entailed, the VA would be able to bear such costs through the realignment of existing resources. Because of the general emphasis in this legislation and existing law on meeting the health-care needs of service-connected disabled veterans, any shift in resources would be to the benefit of those veterans who are owed the greatest obligation by the VA.

## S. 2422: Compensation/DIC COLA

This morning we will also be focusing on issues relating to the VA service-connected compensation program -- including a cost of living adjustment in benefits paid under that program. Specifically, we will be hearing testimony on S. 2422, the proposed "Veterans' Compensation and Benefits Improvements Act of 1986", which I joined the Chairman in introducing on May 8. This measure would provide for a cost-of-living increase in the rates of compensation for veterans who suffer from service-connected disabilities and the rates of DIC for the survivors of veterans who have died from service-connected causes, would modify provisions relating to the administration of the VA's home-loan guaranty program, would revise the Administrator's authority to build and operate parking facilities and collect parking fees at VA Medical Centers, and would authorize prompt implementation of an administrative reorganization in the VA. The measure also includes two provisions, derived from Administration-proposed legislation, relating to the collection of certain debts and to the information that certain fiduciaries of veterans must provide to the VA.

The VA's service-connected disability compensation program is at the very heart of our system of veterans' benefits. This Committee has consistently attached the highest priority to the needs of service-connected disabled veterans and the survivors of those who have made the ultimate sacrifice. The more than 2.2 million veterans who suffer from disabilities resulting from their service and the 340,000 survivors of those who died from service-connected disabilities are and will remain my number one priority.

I'm delighted that the legislation that we agreed to introduce would provide for a compensation and DIC COLA equal to the COLA percentage to be provided for Social Security and VA pension benefits, effective December 1, 1986. According to the most recent estimate by the Congressional Budget Office -- made in February -- that percentage will be 3.4 percent, although informal Budget Committee estimates now predict only a 2-percent increase. As I have noted on numerous occasions, my commitment to this approach remains strong.

Parking at VA Medical Facilities: With respect to the provisions in S. 2422 that relate to parking facilities at VA Medical Centers, I hope that enactment of these provisions will help produce a satisfactory solution to a very difficult situation at a number of VA facilities. For more than 2 years, the proposal for construction of a 120-bed nursing home care unit and parking structure at the VA's Medical Center in San Francisco has been stymied by an impasse that has developed in the appropriation process. This has prevented a terrible parking problem at that facility from being resolved through the construction of an adequate parking garage. In addition, appropriations for much-needed parking facilities at VA Medical Centers in Durham, North Carolina, Syracuse, New York, and Philadelphia, Pennsylvania -- which the VA sought for FY 1986 -- were denied by the Appropriations Committees and the Congress.

In order to resolve this very complex and controversial problem in an equitable and effective fashion, our bill would provide that future funding for the construction, operation, and maintenance of parking facilities would be drawn from a revolving fund, which has been authorized by law since 1979. Fees required to be collected at medical facilities where parking garages are constructed or are altered at a cost of over $500,000 -- and fees authorized to be collected elsewhere -- would be deposited in the revolving fund. As is the case under current law, no fees would be permitted to be charged for a vehicle being used for the transportation of a veteran-patient. I also believe that the proposal should be modified, as suggested by the VFW in its testimony for today's hearing, so as not to allow fees to be collected from individuals coming as volunteers to VA facilities to help VA patients. We have been in contact with the Appropriations Committees regarding this proposal and believe that a cooperative approach will be forthcoming to resolve the problem of funding for needed parking garages.

Mr. Chairman, I also want to take this opportunity to express my thanks to you for including on the hearing agenda this morning S. 2304, a measure I introduced on April 15 to extend for three additional years, through September 1989, the authority set forth in section 2014(b) of title 38, United States Code, for veterans readjustment appointments -- VRA's. Joining as cosponsors of this measure are Senators Matsunaga, DeConcini, Mitchell, Rockefeller, and Hollings.

## Conclusion

In closing, I again thank all of the witnesses for their participation. I look forward to working with the Chairman and the other members of the Committee as we develop legislation from the various bills before us today. I am confident that we'll be able, once again, to develop a bipartisan approach that fulfills our commitment to our Nation's veterans.

# HEALTH CARE, COMPENSATION AND PENSION HEARING

SENATE COMMITTEE ON VETERANS AFFAIRS
20 MAY 1986 0930 RUSSELL 414
HONORABLE JEREMIAH DENTON, U.S.S.

MR. (ACTING) CHAIRMAN, I AM SORRY TO HEAR THAT SENATOR MURKOWSKI IS ILL AND CANNOT RETURN FROM ALASKA FOR THE HEARING. I KNOW THAT HE IS VERY INTERESTED, AS I AM, IN PROVIDING FOR THE HEALTH CARE NEEDS OF THE NATION'S VETERANS.

THIS MORNING'S HEARING ON LEGISLATION THAT PERTAINS TO VETERANS' HEALTH CARE, DISABILITY COMPENSATION, HOME LOAN GUARANTEES, AND OTHER BENEFIT PROGRAMS IS IMPORTANT TO THE WELFARE OF OUR VETERANS. THEY ARE NOT GIVE-AWAY PROGRAMS, BUT BENEFITS THAT VETERANS HAVE EARNED THROUGH SERVICE TO THE COUNTRY.

I AM SURE THE TESTIMONY THAT WILL BE GIVEN TODAY WILL ASSIST IN BLENDING THE LEGISLATION INTO A WELL-ROUNDED AND USEFUL PROGRAM. I APOLOGIZE THAT I WILL NOT BE ABLE TO ATTEND THE FULL HEARING THIS MORNING, BUT THERE ARE THREE EQUALLY IMPORTANT MEETINGS THAT I HAVE TO ATTEND AT THIS TIME.

I WOULD LIKE TO SUBMIT THE REST OF MY STATEMENT FOR THE RECORD, MR. CHAIRMAN.

THANK YOU.

Statement
Senator George J. Mitchell
Committee on Veterans' Affairs
May 20, 1986

Mr. Chairman, I want to join with you and the distinguished ranking member, Senator Cranston, in welcoming the witnesses to this morning's hearings.

There are a number of proposals to be considered so I will confine my remarks to legislation that I have introduced, S 1536, which provides that per diem subsidies paid by the VA for the care of veterans in State Homes shall not be used to offset payments that are made to the Homes under the Medicaid program.

Before proceeding, Mr. Chairman, I want to extend my appreciation for your cooperation in scheduling my legislation for hearing this morning and for making it possible for Bill Carney, the Administrator of Maine's Veterans Home, to appear to day to speak for my legislation.

My legislation would change the present treatment of Veterans Administration per diem payments to State Veterans Homes under Medicaid. While only a small number of State Homes would be affected by this legislation, correcting the present treatment of the payments under Medicaid is extremely important to the affected Homes.

The VA promotes the care and treatment of veterans in State Veterans Homes as one means of developing and maintaining the highest possible quality of care for this nation's elderly veterans. Congress has established two programs under which the VA provides assistance to State Homes.

The first is a grant program authorized by Title 38 U.S.C. 5031-5037. Grants under this program, go to construct new homes or to expand, remodel, or alter exisiting facilities and may not exceed 65 percent of the cost of construction.

The second is a per diem payment program authorized by Title 38 U.S.C. 641-643. Under this program, the VA contributes funds directly to recognized State Homes to help meet the cost of care for eligible veterans in the Homes. Per diem payments under this program are made for domiciliary care, nursing home, and hospital care at set rates, but may not exceed one-half the cost of the veterans' care in the Home.

State Homes are established through legislation enacated by the State legislature, which also determines how the State will fund its share of the Home's operation. Generally, that support is a direct appropriation from the State. Under such an arrangement, the Home's revenues consist of State appropriations and the VA per diem payments.

But a small number of States, including my State of Maine, have chosen to fund the Home's operation through the Medicaid program. Under such an arrangement, the Home's revenues consist of Medicaid and VA per diem payments.

As my colleagues know, the Federal and participating State governments share the cost of Medicaid by means of a variable matching formula. States with Medicaid Veterans Homes then do not directly support their Homes with State revenue, except for the funds allocated to cover the State's share of the Medicaid payments to the Homes.

In determining the extent of medical assistance Medicaid may provide for an individual applicant or recipient, states must consider whether there exists any "third party" liability for the individual's care and services that arises out of injury, disease, or disability.

If a state discovers that a third party is in fact liable for some portion of a Medicaid applicant's or receipient's care, the state must reduce its Medicaid payments to the extent of such third party liability. The Office of General Counsel in the Department of Health & Human Services has ruled that VA per diem payments to State Homes must be treated as a third party liability for purposes of Medcaid. A copy of the General Counsel's decision is attached to my statement.

As a result of this ruling, State agencies which administer Medicaid, in the case of my State, the Maine Department of Human Services, are forced to reduce the Medicaid payments to the Home by an amount equal to the VA per diem payments made on behalf of the Medicaid-eligible veterans residing in the Home.

But veterans throughout Maine argue that the VA per diem should not be considered a resource of the individual because the VA makes the payment to the Home, not the individual veteran. Under Medicaid statutes, 42 U.S.C. 1396a(25) third party liability is to be considered "... as a resource of the individual on whose behalf the care and services are made available."

Veterans in my State have repeatedly and strongly opposed the present arrangement, arguing that it makes no sense for the Congress to authorize the VA to make payments to State veterans Homes on behalf of veterans only to have those funds used by State agencies to replace State and Federal Medicaid dollars, with no benefit to the veteran.

The legislation I have introduced is straight-forward and simple. It says that payments made to State Veteran Homes under section 641 of Title 38 shall not be considered to be a third-party liability under Medicaid.

I believe that this legislation is very important for the limited number of Home now adversely affected by the treatment of the per diem stipend under Medicaid. I do not believe the cost associated with my proposal should stand in the way of its support by this Committee.

Prior to introducing S 1536, I asked the Congressional Budget Office to estimate the cost of enacting the legislation. According to CBO, the cost to the Federal government, to the Medicaid program, would be $2 million a year. State Medicaid costs would increase by a similar amount. A letter to me from Rudolph Penner, the Director of the Congressional Budget Office, on S 1536 is attached to this statement.

This legislation and the underlying question regarding the treatment of the VA per diem stipend is critically important to the veterans in my State. Maine already has a 120-bed veterans home in Augusta which provides an excellent level of care to its resident.

Maine's legislature has passed and Governor Brennan has signed legislation which authorizes the construction of two additinal veterans homes in Maine, a 120-bed home in southern Maine and a 60-bed home in northern Maine. I have attached a letter from VFW Post #9389 in Caribou, Maine, expressing the importance of this legislation in securing the critically needed veterans home in Aroostook County, Maine.

I am interested in hearing from today's witnesses how my legislation might affect the State Home program nationwide. I am also interested in hearing testimony on the provision in the Chairman's health programs improvement package, S 2445, which would require the VA to establish criteria to prioritize state home construction grants.

Once again, Mr. Chairman, I want to express my appreciation to you for your efforts to have S 1536 discussed at today's hearing. I look forward to hearing the testimony from today's witnesses.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

[illegible] 9 [illegible]

The Honorable George J. Mitchell
United States Senate
Washington, D.C. 20510

Dear Senator Mitchell:

This is in response to your letter of February 4, 1985, in which you asked whether certain Veterans Administration payments to the State Veterans Home in Augusta, Maine must be offset against Medicaid payments otherwise due the Home. I have asked the Department's General Counsel to review this matter and his report is attached. Briefly stated, it appears that the Veterans Administration payments must be treated as third party liability payments that must, under applicable laws and regulations, be offset against Medicaid payments due the Home.

We would be happy to discuss these matters with representatives of the State Veterans Home. It is my understanding that representatives of the State Veterans Home have been extended an invitation to meet with staff and officials of the Health Care Financing Administration but have not yet indicated a desire to explore the issue further.

I have forwarded a similar letter to your colleagues on the Maine Congressional Delegation. Thank you for your interest in the Medicaid program.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the General Counsel

Washington, D.C. 20201
February 27, 1987

Report of the Office of the General Counsel on
Whether Veterans Administration Payments to
the State Veterans Home in Augusta, Maine Must
Be Offset Against Medicaid Payments for the
Veterans Home.

## Background:

In determining the extent of medical assistance Medicaid may provide to an individual applicant or recipient, every state must have reasonable standards for considering an individual's income and resources. Section 1902(a)(17)(B) of the Social Security Act, 42 U.S.C. 1396a(a)(17)(B). One resource that a state shall consider is any "third party" liability for an individual's care and services that arises out of injury, disease, or disability. Section 1902(a)(25)(A) of the Social Security Act, 42 U.S.C. 1396a(a)(25)(A). If a state discovers that a third party is in fact liable for some portion of a Medicaid applicant's or recipient's care, the state must reduce its Medicaid payments to the extent of such third party liability.

Applicable regulations allow the state several alternative means of making this reduction. If the third party's liability is clearly established before Medicaid payments are made, the state may offset the third party liability against Medicaid payments due and pay out the amount remaining to the provider. 42 C.F.R. 433.139(b)(1). Alternatively, the state may make a full Medicaid payment and then seek reimbursement from the liable third party to the limit of legal liability. If this option is selected, the state must seek reimbursement from the party within 30 days after the end of the month in which payment is made. 42 C.F.R. 433.139(d)(2).

Questions have arisen as to whether certain Veterans Administration ("VA") payments made to Medicaid recipients constitute third party liability payments which must be offset against Medicaid payments under the above-described statutory provisions and regulations.

Analysis:

The payments at issue are made pursuant to 38 U.S.C. 641. This provision authorizes a per diem payment for each veteran in a home recognized by the VA Administrator as a State Home eligible for payment under the statute. See attached memorandum from the VA's General Counsel. The amount of payment is fixed by law and varies depending on the type of care provided by the facility. The types of care supported by these payments include hospital care, nursing home care, and domiciliary care. 38 C.F.R. 17.166, 17.166a, and 17.166b. The critical question is whether the type of care funded by the VA payments to the State Home in Augusta falls within the definition of third party liability payment under Medicaid.

Medicaid regulations define third party as "any individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient." 42 C.F.R. 433.136. Interpretive materials further note that VA payments may, in general, be treated as third party payments. HCFA Regional Office Manual, section 6-50-21 (5). Thus, it is clear that the VA is a third party.

Moreover, it is clear that the VA payments to the Augusta State Veterans Home are for "medical costs" within the meaning of the Medicaid program. The VA payments to the Augusta State Veterans Home are made exclusively for the costs of nursing home care and do not include any payments for a lower level of care. For purposes of these VA payments, nursing home care is defined as accommodation of persons "who require skilled nursing care and related medical services" which are "prescribed by, or performed under the general direction of, persons duly licensed to provide such care." 38 U.S.C. 101(28). Thus, the payments at issue are for medical costs and as such must be offset against the Medicaid payments otherwise due the Home.

## Conclusion

The VA payments under 38 U.S.C. 641 to the Augusta, Maine State Veterans Home must be treated as a third party liability for purposes of determining the Home's level of reimbursement. Consequently, the state is required to offset these VA payments against the payments that would otherwise be due the Home under Medicaid. Failure to make this reduction in Medicaid payments could deprive the state of federal financial participation in the Medicaid payments at issue, pursuant to 42 C.F.R. 433.140.

**CONGRESSIONAL BUDGET OFFICE**
**U.S. CONGRESS**
**WASHINGTON, D.C. 20515**

**Rudolph G. Penner**
**Director**

June 14, 1985

Honorable George J. Mitchell
United States Senate
Washington, D.C. 20510

Dear Senator:

As you requested in your letter of May 6, 1985, we have reviewed your proposed legislation to amend Title 38, United States Code, to provide that per diem subsidies paid by the Veterans Administration for the care of veterans in State homes shall not be used to offset reimbursements to the home under the Medicaid program. Based on our analysis, we estimate that enactment would increase federal Medicaid costs by $2 million a year. State Medicaid costs would increase by a similar amount.

Our estimate is based on current Medicaid enrollment at those homes that would be affected by this proposal. Currently only four Medicaid-certified state nursing homes care for veterans who are Medicaid recipients: Homelake, Colorado has 17 such veterans; Augusta, Maine has 86; Oxford, New York has 109; and King, Wisconsin has 280. If the Veterans Administration subsidies were not considered third-party liabilities, then the Medicaid program would be required to pick up these costs. Depending upon the match rate, the federal government would pay varying shares of the costs in each state. The estimate assumes that no additional state homes would apply for Medicaid certification as a result of this proposal. If additional state homes did apply, the costs could be significantly above those estimated.

We would be pleased to respond to any questions you might have on this estimate. Your staff may contact Anne Manley (226-2820) with detailed questions.

With best wishes,

Sincerely,

Eric Hanushek
for Rudolph G. Penner

VFW
DEPARTMENT OF MAINE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

Veterans Of Foreign Wars
Post #9389
Van Buren Road
Caribou, Maine 04736

May 15, 1986

The Honorable Senator George Mitchell
Russell Senate Office Building
Room 344
Washington, D.C. 20510

Dear Senator Mitchell:

On behalf of the Veterans of Foreign Wars. Post #9389, in Caribou, Maine, we would like to strongly endorse your efforts to resolve the unfairness of the veterans per diem stipend being used as a third party liability as it applies to medicaid funding of care to veterans in State Veterans Homes.

We are particularly concerned about this issue at this time because of recent legislation passed by our Maine State Legislature, authorizing the establishment of two additional nursing homes for veterans in the northern and southern sections of Maine in order to meet the demands of the aging veterans in need of such care.

Under current law, the original intention of Congress in developing the per diem stipend, is not being realized. By factoring in the stipend into the medicaid payment system, the funds are not available for operational costs at the State Veterans Homes. The lack of these funds seriously hampers efforts at the Homes to develop a high quality program for patients in need of care in these facilities. We applaud the original intention of Congress to provide the stipend as a benefit to well deserving veterans who now need help. Additionaly, the Maine Veterans Home program has shown itself to be the most cost effective and highest quality nursing home institution in our State.

We urge the Committee on Veterans Affairs, and the United States Congress to look favorable upon your legislation to rectify this unfair situation. The success of this legislation is critical to the realization of a long awaited dream of Aroostook County Veterans, the construction of a State Veterans Home here near their homes and families.

We offer our most fervent hopes and gratitude for your ongoing efforts in this regard.

Sincerely,

Albert E. Gahagan
Albert Gahagan, Commander
Veterans of Foreign Wars

Meo J. Bosse
Meo Bosse
Legislative Officer

SAFEGUARDING THE RIGHTS OF THE VETERAN AND HIS DEPENDENTS SINCE 1899

STATEMENT BY SENATOR STROM THURMOND (R-SC) BEFORE THE SENATE COMMITTEE ON VETERANS' AFFAIRS REFERENCE HEARING ON VETERANS' HEALTH CARE AND BENEFITS IMPROVEMENTS FOR 1987, TUESDAY, MAY 20, 1986, 9:30 A.M., ROOM 418 RUSSELL SENATE OFFICE BUILDING.

MR. CHAIRMAN:

I COMMEND YOU FOR HOLDING THIS HEARING TODAY ON THE IMPORTANT SUBJECT OF THE MEDICAL CARE AND VARIOUS BENEFITS WE AS A NATION PROVIDE FOR THE VETERANS OF OUR ARMED FORCES.

WE ARE FACED AGAIN THIS YEAR, AS I EXPECT WE WILL BE IN YEARS TO COME, WITH THE DIFFICULT JOB OF CONTINUING TO PROVIDE THE BENEFITS OUR VETERANS NEED AND DESERVE WHILE PRACTICING FISCAL RESPONSIBILITY. AS I HAVE STATED MANY TIMES BEFORE, ONE OF THE MOST IMPORTANT BENEFITS WE CAN PROVIDE TO VETERANS, AND TO ALL OTHER AMERICANS, IS A SOUND ECONOMY BASED ON A FISCALLY RESPONSIBLE LEVEL OF FEDERAL SPENDING.

WE ARE CONTINUALLY REMINDED OF THE BURDEN WE HAVE PLACED ON OURSELVES AND ON FUTURE GENERATIONS OF AMERICANS AS A RESULT OF YEARS OF DEFICIT SPENDING, AND IT PLEASES ME, THEREFORE, TO SEE THAT ALTERNATIVE AND MORE COST EFFECTIVE MEANS OF PROVIDING QUALITY SERVICES TO VETERANS ARE NOW BEING CONSIDERED. I HAVE HEARD THE CRITICS CLAIM THAT THOSE WHO CONSIDER NEW APPROACHES FOR OUR HEALTH CARE AND BENEFITS DELIVERY SYSTEM HAVE AS THEIR MOTIVE THE DISMANTLING OF THE VETERANS' ADMINISTRATION. WELL, I LOOK FORWARD TO NEW WAYS IN WHICH WE CAN PROVIDE THE NECESSARY AND DESERVED CARE AND BENEFITS TO OUR VETERANS, BUT I CERTAINLY DO NOT SEEK THE DOWNFALL OF THE VETERANS' ADMINISTRATION. IN

FACT, I HAVE INTRODUCED LEGISLATION REPEATEDLY TO UPGRADE THE VETERANS' ADMINISTRATION TO A CABINET LEVEL AGENCY.

MR. CHAIRMAN, AS WE RECEIVE TESTIMONY FROM THE VETERANS' ADMINISTRATION AND THE VETERANS' SERVICE ORGANIZATIONS REGARDING HEALTH CARE, COMPENSATION AND PENSION, AND VARIOUS OTHER VETERANS' BENEFITS, I WANT TO EMPHASIZE MY FULL SUPPORT OF THE PROVISIONS INCLUDED IN S. 2422 AND S. 2445, THE VETERANS' COMPENSATION AND BENEFITS IMPROVEMENTS BILL AND THE VETERANS' HEALTH CARE BILL FOR 1986. I AM PROUD TO HAVE COSPONSORED BOTH OF THOSE PIECES OF LEGISLATION.

I AM HAPPY TO SEE THAT WE HAVE PROVIDED FOR A COST OF LIVING INCREASE FOR THOSE VETERANS RECEIVING DISABILITY COMPENSATION OR PENSION IN FISCAL YEAR 1987. THE SENATE HAS TAKEN THE CORRECT APPROACH TO ENSURING A COST OF LIVING INCREASE BY TYING IT TO THE CONSUMER PRICE INDEX AS REPORTED BY THE BUREAU OF LABOR STATISTICS EACH YEAR.

ANOTHER AREA THAT DESERVES OUR ATTENTION AND SUPPORT INVOLVES THE INITIATIVE TAKEN TO PREVENT FURTHER LOSSES IN THE HOME LOAN GUARANTY PROGRAM AS A RESULT OF THE UNMANAGEABLE LEVEL OF ACQUIRED PROPERTY IN THE VETERANS' ADMINISTRATION'S INVENTORY. WE CANNOT ALLOW A SITUATION, SIMILAR TO THAT WHICH EXISTS IN HOUSTON, TEXAS, TO OCCUR IN THE FUTURE. THE INTEGRITY AND LIFE OF THE PROGRAM ARE AT STAKE, AND I COMMEND THE CHAIRMAN FOR HIS EFFORTS TO SEE THAT THE FEDERAL GOVERNMENT IS ABLE TO CONTINUE TO PROVIDE THIS BENEFIT TO VETERANS.

THE PROVISIONS OF S. 2445 ARE FINE EXAMPLES OF THE INSIGHT BEING EXHIBITED IN CONGRESS WITH RESPECT TO VETERANS HEALTH CARE

AND I LOOK FORWARD TO THEIR PASSAGE. RANDOM, THOUGHTLESS, ACROSS THE BOARD CUTS IN THE VETERANS' HEALTH CARE SYSTEM ARE NOT THE ANSWER TO OUR BUDGETARY PROBLEMS. THAT RATIONALE SHOULD GIVE WAY TO MORE INNOVATIVE APPROACHES TO HEALTH CARE DELIVERY AS EXPRESSED IN THIS LEGISLATION.

I WOULD LIKE TO TAKE A MOMENT AND REFER TO THE LEGISLATION, WHICH I RECENTLY INTRODUCED, ADDING TWO DISORDERS TO THE EXISTING LIST OF TEN PRESUMPTIVE DISORDERS FOR THE PURPOSES OF PROVIDING SERVICE-CONNECTION TO FORMER PRISONERS OF WAR. S. 2168 IS AN IMPORTANT PIECE OF LEGISLATION. I FIRMLY BELIEVE THAT WE AS A NATION SHOULD DO ALL IN OUR POWER TO PROPERLY COMPENSATE THOSE WHO IN SERVICE TO THEIR COUNTRY WERE FORCED TO ENDURE THE HARDSHIPS AND CRUELTY OF CAPTIVITY AS PRISONERS OF WAR. IT IS MY SINCERE HOPE THAT THIS COMMITTEE WILL FAVORABLY CONSIDER THIS BILL WHEN MARKING-UP AND REPORTING THIS YEAR'S COMPENSATION AND BENEFITS' IMPROVEMENTS BILL.

IN CONCLUSION, MR. CHAIRMAN, I WISH TO EXPRESS MY DESIRE TO SEE THE HOUSE ACT FAVORABLY UPON S. 1887, THE VETERANS' COMPENSATION AND BENEFITS IMPROVEMENTS ACT OF 1985, WHICH IS PENDING IN THE HOUSE VETERANS' AFFAIRS COMMITTEE. THE PROVISIONS OF THAT BILL ARE IMPORTANT TO OUR ABILITY TO CONTINUE TO PROVIDE OUR VETERANS WITH THE BENEFITS THEY TRULY DESERVE.

STATEMENT OF
JOHN W. DITZLER
CHIEF MEDICAL DIRECTOR
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
May 20, 1986

Mr. Chairman, I am pleased to be here this morning to present the views of the Veterans' Administration on pending legislation principally affecting the VA's health-care program.

## PROVIDE AUTHORITY FOR RESPITE CARE

Section 2 of the bill would authorize VA to provide needed "respite care" to veterans eligible for hospital or nursing home care. Respite care represents a relatively new concept for VA which we wish to evaluate on a pilot basis. In essence, "respite" care refers to providing brief periods of care in VA health facilities on a prearranged basis to chronically-ill persons in order to relieve members of the veteran's family and others in the household from the severe physical and emotional burdens of caregiving. The difficulties of caring for these veterans at home often become exacerbated during the course of illness, particularly if there is no break for the family. The patient may also benefit directly from respite care by virtue of treatment received in the institution. The critical element of respite arrangements is that the respite is planned in advance for the benefit of the caregiver, rather than being incidental to the provision of necessary medical care of the patient.

VA currently lacks clear statutory authority to furnish respite care. We recommend that such a program be initiated on an evaluative, pilot basis, and that its scope be limited to those veterans having the highest claim to VA health care, service-connected veterans. Under our proposal, we would anticipate providing respite care at a limited number of facilities in conjunction with hospital based home care programs in one-week lengths of stay for up to four times a year. This would help us determine whether care would be furnished in beds that are staffed and would otherwise be unoccupied, since respite patients generally would receive nursing level care. We would also limit the scale of the pilot program so that there would be no additional costs. We believe that a three-year program, such as proposed in S. 2388, would provide us with sufficient experience to determine the future of respite care by VA.

## ALTERNATIVES TO HOSPITAL AND NURSING HOME CARE

Section 3 of this bill would authorize VA to furnish veterans with noninstitutional care on a contract basis as an alternative to inpatient hospital and nursing home care. First, it would grant the Administrator authority to furnish hospital based home care to any veteran when such care would obviate the need for inpatient care. Second, it would authorize VA to contract for non-medical support services to assist veterans to perform necessities of daily living if such services would obviate the need for nursing home care.

VA generally favors noninstitutional alternatives to inpatient care, but we cannot support this proposal. First, it would establish virtually unlimited contract authority to furnish hospital based home care to any veteran. This open-ended eligibility represents a substantial departure from the longstanding statutorily based policy that, except in limited circumstances and for limited categories of veterans, VA should, as much as possible, furnish hospital and medical services to veterans in facilities under the jurisdiction of the Administrator. That is particularly true in the case of nonservice-connected veterans.

The amendment in this bill would effect far-reaching changes in the scope of hospital based home care by expanding that service substantially to include social support services, such as homemaker or chore services. Similarly, the bill would amend section 620 of title 38 to authorize an even broader array of nonmedical services necessary to help any veteran with a "functional deficiency" perform tasks of daily living.

As we have stated on several occasions in commenting on similar legislative proposals, Congress has provided, in 38 U.S.C § 4101, that "[the] primary function of the Department of Medicine and Surgery shall be to provide a complete medical and hospital service." That mandate contemplates that VA will provide veterans with all needed medical services, either in VA operated facilities, or in limited circumstances when necessary, in facilities for which the VA contracts. Furnishing homemaker and transportation services, and personal care services such as feeding, washing, and dressing duplicates, in large measure, the assistance for which the basic aid and attendance allowances are currently paid to many veterans. It would also duplicate the availability of such services which are often available from community resources. We do not recommend a departure from the longstanding public policy that the Department of Medicine and Surgery be responsible for medical services for veterans, while other needs be met by other benefits or resources in the community.

## CONTRACT RESIDENTIAL CARE FOR CHRONIC MENTAL ILLNESS

Section 4 of the draft bill would authorize VA to contract with community residential treatment facilities for the care of veterans who are being furnished VA inpatient care for chronic mental illness.

VA has been studying this concept, and, in general, we favor the enactment of a provision which would grant us the contracting flexibility which prevails in our drug and alcohol dependence treatment program. As you know, Mr. Chairman, we have a broad network of contract arrangements for providing halfway house care under that program. This has proven a cost-effective approach, which, in our judgment, could be applied here to diminish substantially lengthy hospital stays for many veterans suffering from chronic mental illness. As such, we believe we can manage such new authority within existing resources.

We would urge the committee to modify this measure, however, to eliminate elements which are unnecessarily restrictive. Specifically, we recommend that the provision requiring VA to furnish case management services be deleted. We note as well that this measure would require VA to provide a relatively detailed report on the agency's experience with this authority within a year after enactment of this provision. Since the measure requires VA to promulgate regulations prior to contracting for services, it is highly unlikely that we can both implement this program meaningfully and evaluate its effectiveness in this time frame. We would also recommend that this program be initially authorized for three years and would recommend that an evaluative report be submitted 24 months after enactment.

## LICENSURE REQUIREMENTS FOR VA PSYCHOLOGISTS

Section 5 of the bill would amend section 4114(d) of title 38 to permit VA to appoint psychologists who are not licensed in a "State" if they will be working in a research or academic post where they have no patient care responsibility. Currently VA has identical authority to hire physicians, dentists, podiatrists, and optometrists who are not licensed in a State, which has proven helpful.

VA supports the intent of this proposal which appears to be to give VA more flexibility in the hiring of research psychologists. We would also recommend one additional flexibility provision be built into the bill. We suggest that authority be granted to waive the internship requirement for psychologists included in section 4105(a)(8), and that VA be authorized to hire such research psychologists using only term appointments lasting for as long as their research would continue. We would be pleased to work with the committee in development of this proposal.

## VA OPERATING BED PROVISION

Section 6 of the bill would amend the statutory provision directing VA to operate 90,000 hospital and nursing home beds to include domiciliary beds within that formulation.

with the inclusion of domiciliary beds VA would be above the 90,000 operating bed level. Since the original 90,000 bed minimum was enacted dramatic changes have taken place in the delivery of medical care. These changes, such as increased outpatient care, including minor surgery on an outpatient basis, have diminished the need for inpatient hospital stays. If the Congress continues to believe that a total minimum number of beds is needed, we do favor its addition of domiciliary beds.

## REVISION OF STATE HOME GRANT PROGRAM

Section 7 of the bill would very substantially change the process by which VA funds are awarded to applicants for State home grants. Under existing law, the VA must approve a grant application if that application meets the requirements set by law. The statute leaves us little discretion to rank grant applications according to priorities or "established priority." As a result, the VA approves grants as funds become available in the order in which grant requests are received.

Under this proposal, VA would be required to grant awards on the basis of pre-established criteria for prioritizing projects. The bill calls for VA to develop those criteria and to make its relative priority determinations from among approved applications. Monies available for these grants would then be allocated among those approved projects in accordance with the priorites that had been established. Enactment of this proposal would revise a long-standing process, and, in our judgment, could discourage some states from applying for State home construction grants while encouraging others to apply.

As drafted, this measure appears to require a State to incur all the expense associated with submitting a formal application (up to 10% of the project's cost) and await project approval, without any assurance that that project, even if approved, will be funded. Because of this uncertainty, we anticipate that some States would be less likely to plan and request funding for State home projects if this proposal were enacted.

We recognize that there may be criticism that the existing process does not give sufficient weight to relative need among State home projects. The current program has worked well for many years. We would acknowledge, however, that allowing VA to target grant money to areas of greatest need could encourage some non-participating States to submit applications. An effective targeting provision could be a useful tool in assisting the VA to better manage its nursing home provider mix. Although we believe it is premature to make any decision to change the current approval process at this time, there may be options similar to the concept contained in this bill, which would provide additional flexibility. More time should be allowed, however, to study all of the ramifications of these options before a change is made to the existing procedure.

Section 7 would also limit the existing scope of grant-eligible projects under the State home program. As proposed, construction grants would no longer be available to assist States to expand existing buildings for the provision of hospital care in State homes. In view of the pressing need for long term care facilities, we have no objection to this provision.

IONIZING RADIATION REGISTRY

Section 8 of S. 2388 would require that the Veterans Administration establish a registry of veterans exposed to ionizing radiation who have requested VA care for disabilities which may be related to such exposure, who have claimed VA disability compensation for disabilities allegedly resulting from radiation exposure, or who died leaving survivors who have claimed VA death benefits based on the veteran's exposure to radiation. The registry would be required to include, for each veteran, detailed medical data identified in the bill, data on the veteran's benefits claim, and an estimate of the radiation dose the veteran received. Finally, the VA would be required to analyze the registry data and report to the Congress regarding the analysis, and the Advisory Committee on Environmental Hazards would be required to review and comment on the analysis. We support the concept embodied in this proposal for a registry, which is to assure access to information regarding veterans exposed to ionizing radiation. We cannot support this specific proposal, however. Most of the information which the proposed registry would include is now available to the VA, but it is often not easily accessible. For example, VA has established a method for identifying veterans who apply to the VA for inpatient care for disabilities possibly related to exposure to radiation. This system permits us to retrieve from the VA's automated Patient Treatment File summary data concerning these veterans and the location of their permanent medical records. Similarly, the Department of Veterans Benefits established a Special Issue Rating System (SIRS) which collects data on claims based on exposure to ionizing radiation. This system includes service dates, the disabilities claimed, the VA's decision on each disability with respect to service-connection, and the date of the latest rating decision.

We recommend that as an alternative to the registry proposed in this bill, the VA develop a more limited registry which would, in effect, permit VA greater access to the information which is already available. The registry would also combine information from the Defense Nuclear Agency with information in existing VA files. Development of this more limited registry would be more cost-effective than the proposal made in this bill, and would provide the information that the VA, the Congress, and the affected veteran population needs.

We also cannot support the provision in this bill which requires VA to analyze the data in the proposed registry and report to the Congress regarding the analysis. This provision could be construed as requiring that VA perform a morbidity study of veterans included in the ionizing radiation registry. It has already been determined by the Office of Technology Assessment and the Committee on Interagency Radiation Research and Policy Coordination that such a study, in any form, would not be feasible.

## REQUIREMENT THAT HEALTH CARE PROVIDERS ACCEPT MEDICARE AND VA BENEFICIARIES ON A SIMILAR BASIS AND ACCEPT VA PAYMENTS AS PAYMENTS IN FULL

Mr. Chairman, we appreciate your introduction of this bill at our request. S. 2174 is intended to limit the increase in the costs to VA of our contract hospitalization program by requiring that non-Federal providers of hospital care and services under the Medicare program must accept VA beneficiaries as patients to the same extent as Medicare beneficiaries, and must accept VA payments for their services to VA beneficiaries made in accordance with VA regulations as full payment for such services. We anticipate that enactment of this provision would permit VA to lower its contract care costs and we strongly support its enactment.

## VA ENFORCEMENT OF STATE AND LOCAL TRAFFIC LAWS

Section 2 of S. 2388 would amend section 218 of title 38 to authorize Veterans Administration police officers to enforce State and local traffic laws for acts occurring on Veterans Administration property. This provision is identical to an adminstration proposal which was transmitted to the Committee on March 10, 1986.

Current law authorizes VA police officers to enforce only Federal laws and regulations promulgated by the Administrator. In order for us to enforce agency regulations, the local United

States District Courts, which universally refuse to hear violations of agency regulations, must enter an order or publish a rule permitting us to refer violations of these regulations occurring on VA property to U.S. Magistrates for disposition. Under these circumstances, authority for effective security and traffic control is seriously deficient. This measure would provide authority for the VA, with the cooperation of State and local authorities, to correct those situations where VA police officers lack authority to control automobile traffic and parking on VA property. Such authority would improve the VA's ability to control automobile parking and traffic on VA grounds by the issuance of citations under State and local codes and the prosecution of those violations in State and local traffic courts. We strongly support this measure.

## SERVICES TO OVERCOME DISABILITIES PREVENTING PREGNANCY

Section 3 of S. 2388 would authorize VA to furnish services to achieve pregnancy in a veteran, or a veteran's spouse, if necessary to overcome a service-connected disability which impairs the veteran's procreative ability. Thus, if a woman veteran is unable to become pregnant due to damaged fallopian tubes resulting from a service-connected disability, the VA could furnish, or pay for artificial insemination or in-vitro fertilization services for the woman. Similarly, VA could furnish such services to a woman whose spouse is unable to impregnate her due to a service connected disability.

Although infertility per se is not a service-connected disability, there exist compelling cases of veterans who have suffered service-incurred injury or disease with resultant impairment of their procreative ability. Advances in medical technology and technique have begun to make it possible for medical science to help some affected couples. Nevertheless, far-reaching philosophical and practical questions regarding the appropriateness of any VA medical assistance to achieve pregnancy in a veteran or a veteran's spouse have vexed us. In addition we note that the Office of Technology Assessment is embarked on a detailed analysis of this subject. Considerably more research and inquiry is necessary in this field; therefore, we recommend against this provision.

## BEREAVEMENT COUNSELING

Section 4 of S. 2388 would amend title 38 to authorize VA to provide a period of bereavement counseling to family members who were receiving VA counseling services in connection with treatment of the veteran at the time of death. Such services could be authorized for up to six months under this provision.

Bereavement counseling is an integral and basic component of hospice care. The Joint Commission on Accreditation of Hospitals has published hospice standards with bereavement counseling as a required service. In the May, 1985 survey of VA Medical Centers' activities for the terminally ill patient, 66% identified bereavement counseling as a necessary and desired adjunct to the care of these patients. The increasing interest within the VA in hospice care has focused attention upon the need for bereavement counseling. Thus, we recommend modification of this measure to limit the provision of bereavement counseling to services furnished in a hospice setting. With such a revision, we would favor section 4. We project that the enactment of such a provision would not impose significant additional costs.

## DOMICILIARY CARE ELIGIBILITY

Section 5 of S. 2388 would amend title 38 to change and clarify the eligibility criteria for domiciliary care. It would provide that to be eligible for domiciliary care, a veteran must need such care and be either (1) service-connected, or

(2) be incapacitated from earning a living and have no adequate means of support.

Under existing domiciliary care eligibility provisions the law appears to impose more stringent requirements on the service-connected veteran than on other veterans. Thus, to be eligible for domiciliary care, the service-connected veteran must have a permanent disability, tuberculosis, or a neuropsychiatric ailment; be incapacitated from earning a living; and have no adequate means of support. In contrast, statutory provisions governing domiciliary eligibility for other veterans impose none of these requirements, and condition eligibility on an "inability to defray" and a need for such care. We believe the proposed change in eligibility rectifies this inequity. We favor its enactment.

## EXPANSION OF ELIGIBILITY FOR READJUSTMENT COUNSELING SERVICES

Section 6 of S. 2388 would authorize the VA to provide readjustment counseling to (1) persons still on active duty with the Armed Services who served during the Vietnam era, and (2) to those who served in the Armed Services after the Vietnam era in combat situations. We believe our readjustment counseling program has been an effective one, and one which could benefit active duty personnel who served in Vietnam as well as in combat areas such as Grenada and Lebanon. In that connection, we would support an amendment to section 612A to extend eligibility for such services to those veterans who served on active duty during a period after May 7, 1975 in an area in which hostilities occurred. We see no need, however, for extending such eligibility to active duty members. VA would welcome the opportunity to provide such needed services to active duty personnel pursuant to "sharing" agreements authorized by Public Law 97-174. As there already exists a vehicle for providing these unique VA health care services to active duty personnel, albeit subject to DoD reimbursement for those services, we do not favor enactment of that facet of section 6.

## RESPITE CARE PILOT PROGRAM

Section 7 of S. 2388 would authorize establishment of a three-year pilot program under which VA may furnish respite care to certain compensably rated service-connected veterans. The measure would authorize the provision of VA hospital or nursing home care of limited duration, on an intermittent basis for the purpose of helping the veteran to continue to reside primarily at home.

As discussed above, we strongly favor the enactment of this provision.

PILOT PROGRAM FOR NONINSTITUTIONAL CARE

Section 8 of S. 2388 would require VA to conduct a 4-year pilot program at ten geographic sites through which par- ticipating veterans would receive appropriate health and health-related services such as homemaker, personal care, and transportation services. VA would be required to furnish appropriate "health-related" services solely by contract with appropriate public and private agencies as well as to provide "case management" services (as defined) to each participant. The measure sets additional requirements as to the program's design, and requires VA to evaluate the effectiveness of providing alternative modes of care, as well as to assess the impact of that effort. VA favors the basic concept of developing alternatives to institutional care, and accordingly, we operate programs such as adult day health care and hospital based home care as alternatives to institutional care and have sought authority such as proposed in this bill to operate a respite care pilot program. We do not favor the particular program that is proposed, however. Although the pilot program might provide VA with the means to evaluate the benefits of providing new health-related services, the provision is unduly prescriptive in directing the scope and operation of the pilot program. We object to the fact that this provision would mandate the conduct of this program.

Moreover, we see no need for Congress to mandate the design of such an effort, such as in setting in law specific minimum numbers of geographic areas, the use of specific numbers of VA geriatric evaluation units, and the degree to which VA must contract for services. In many respects, the requirements of the measure are so specific that they deprive VA of the latitude needed to derive real benefits from any such pilot program. Finally, we cannot favor this provision because of the projected costs of the program.

## REGULATIONS GOVERNING PROVISION OF HEALTH CARE BENEFITS

Section 9 of S. 2388 would amend section 621 of title 38, which directs the Administrator to promulgate rules and regulations which are necessary and appropriate for the efficient provision of VA health care. We agree that it is appropriate to add references to "medical services" to this section, but see no reason to delete the long-standing provision currently set forth in section 621(2) and recommend against this change.

## EXTEND CONTRACT CARE TO VETERANS MEMORIAL MEDICAL CENTER IN THE PHILIPPINES

Section 10 of S. 2300 would extend the VA's authority to provide payment for care to U.S. veterans in the Philippines in the Veterans Memorial Medical Center and to make grants of up to $500,000 annually to the VMMC for replacing and upgrading equipment and rehabilitating its physical plant and facilities. Before and during the Second World War, thousands of Filipinos served in or with the United States Armed Forces in the Philippines. Many of these veterans were casualties of that War. This Country has consistently reaffirmed its moral obligation to provide medical care and treatment for these veterans.

In 1948, Congress authorized a five-year grant program to provide medical benefits to Filipino veterans, including the construction and equipping of a hospital in Luzon. That hospital, which is now the Veterans Memorial Medical Center, was turned over to the Philippine Government in 1953. However, Congress provided and regularly extended authority to VA to provide care to United States veterans in the VMMC and grants to that facility to continue the high standard of medical care to United States veterans.

Although we believe that it has always been the clear intent of Congress that the Philippine Government should take full responsibility for the VMMC, we believe that the authority to provide grants to the VMMC, as well as authority to provide contract care to U.S. veterans in that facility should be continued. To terminate these grants now could jeopardize the operation of the VMMC and its ability to satisfactorily maintain its complex and replace and update essential medical equipment and supplies. Because of the need for VA assistance for these veterans, we also recommend that the authorities to provide contract care and grants be extended for an additional five years, through September 30, 1995, instead of three more years, as proposed in this measure.

## PROGRAM OF INDEPENDENT LIVING SERVICES

Section 11 of S. 2388 would amend the provisions of the chapter 31 pilot program of independent living services (38 U.S.C. § 1520). The amendments would make the program a permanent part of the benefits and services provided under chapter 31; remove the limitation that the program be conducted in various geographic regions of the United States; and eliminate the report to Congress required by the original provisions of law.

Based upon initial study data concerning implementation of this pilot program, the VA determined that the pilot program of independent living services and assistance produced favorable results for many of the veterans who availed themselves of services. However, the data base for the study was too small to draw definitive conclusions concerning effectiveness of the program. Additional data over a longer period would provide a better evaluation of the outcomes of the program. Therefore, in a report entitled "Supplemental Report of the Program of Independant Living Services and Assistance, Section 1520(b), title 38, United States Code," submitted to Congress on August 26, 1985, the VA proposed that the program of independent living services be continued as a pilot project for a period of 3 additional years.

Accordingly, we would oppose enactment of the provisions of this section, but would urge favorable consideration be given to the proposed pilot program extension we have recommended.

EXTEND STATE HOME GRANT AUTHORITY

Section 12 of S. 2388 would extend, for three-years, VA's authority to provide grants to States for the construction or acquisition of State home facilities for furnishing domiciliary and nursing home care, and for remodeling or renovation of State home facilities for furnishing hospital, domiciliary and nursing home care. This authority will expire at the end of this fiscal year. VA strongly supports an extension of this program.

This important cost-sharing program makes it possible to extend medical care to veterans beyond that which can be provided in VA facilities. It is a cost-effective approach, with Federal participation limited to no more than 65 percent of the cost of any one project.

There are now State homes in 35 States. Nursing home care is provided in 45 homes, domiciliary care in 43 homes, and hospital care in seven homes. From Fiscal Year 1966 through Fiscal Year 1985, approximately $179 million was obligated in support of new nursing home care and domiciliary beds and for remodeling and modifying existing buildings. Eighty-three percent of the funds have been used for bed-producing projects. The remainder has been used for remodeling and renovation. The estimated cost of extending this authority for Fiscal Year 1987 would be $42.4 million and $42 million for each of the subsequent years. Because of the importance and effectiveness of this program, we favor extending this authority for an additional five years instead of three years, as proposed in the bill.

In this connection we also recommend that you eliminate the limitation in law which provides that no one State may receive in any fiscal year more than one-third of the amount appropriated in that fiscal year for grants to assist States in the acquisition or construction of State veterans' homes. This limitation was enacted to prevent perceived abuses in the grant program. At the time, it was believed that few States had received inequitably large grants. This limitation has not, however, prevented the approval of any State home grant request. Because Congress typically permits funds appropriated for State home construction grants to remain available for three fiscal years, a large grant can be funded from more than one fiscal year's appropriation. We proposed repeal of this provision as part of our legislative program because the only effect of this limitation is to delay approval of large

State home grant applications until enough money to fund the grant can be accumulated from different fiscal years' appropriations.

STATE HOME PER DIEM PAYMENTS

Mr. Chairman, you also asked us to comment on S. 1536.

This measure would prevent the reduction of Medicaid payments to States for the care of veterans in State homes by an amount equal to VA per diem payments. Currently, the Department of Health and Human Services requires such reductions. As a result, enactment of this bill would permit State homes to receive the full Medicaid and VA per diem payments for any Medicaid eligible veteran.

One of the purposes of the VA per diem payment program is to encourage States to establish, operate, and partially fund State veterans' homes, and thereby relieve the Federal Government of some of its obligation to care for eligible veterans. In fact, this was the original purpose of Federal Government payments to State homes when the program was first enacted in 1888. The per diem payment program has thus always been considered a cost-sharing undertaking in which State and Federal Governments work together to care for veterans. Under the per diem payment program, therefore, like any other cost-sharing program, it is expected that States will find the funds to meet their share of the cost of maintaining veterans in State homes. VA has not sought to intrude upon how States fund the portion of their homes' operations which are not covered by VA payments. This bill, however, might permit some State homes to fund almost all of their operating costs from Federal sources. This would appear to be contrary to the Congressional intent that the per diem payment program be a cost-sharing undertaking of the State and Federal Governments. Although we anticipate no significant costs to the VA resulting from the enactment of this provision, it would result in additional costs to the Medicaid program. We understand the Administration opposes this provision, but we recommend you seek the views of the Department of Health and Human Services on the bill.

## PARKING FEES

Mr. Chairman, you have also asked us to address a proposal which would impose mandatory parking fees at certain VA medical centers for visitors, employees and all others having business at the centers, but there would be no charge for vehicles bringing veterans to the centers for examination or treatment. The centers affected would be those at which a parking garage costing more than $500,000 became available after September 30, 1986; parking fees would be applied to all parking at any such center. The Administrator would continue to have discretionary authority to impose parking fees at all other VA medical centers. Fees would be calculated to recover, to the extent reasonable under the circumstances, the maintenance and operation costs of the parking facilities at a medical center. The Administrator would be authorized to operate medical center parking facilities with VA personnel or by contract.

Mr. Chairman, parking facilities are an integral part of our medical centers, and are essential to delivering health care to our veterans. Veterans, visitors, VA volunteers, and employees all need access to parking located in close proximity to VA medical facilities.

We recognize from our efforts to win support in Congress for needed new parking facilities that there is strong sentiment for the imposition of fees for parking at VA facilities. We also recognize the apparent linkage between funding needed parking facilities and providing that at least some of the persons using those facilities contribute to their operation. It should be noted that the VA already has the authority to impose parking fees at our medical facilities and an agency task force is developing recommendations for implementing that authority. We would be pleased to keep the Committee abreast of our efforts in his regard. Accordingly, we do not believe the enactment of this new authority is necessary.

We oppose, however, the provisions of this bill which would establish a funding mechanism for the provision, maintenance, and operation of parking facilities at all medical centers. Under this measure any appropriations provided for these purposes, and all parking fees, would be required to be placed in a new, parking revolving fund. The intent appears to be to clearly establish the parking revolving fund as the exclusive source of funding for parking facilities after September 30, 1986. Expenditures from the revolving fund for parking facilities expenses could be made only if authorized in appropriation acts. Under existing law a similar parking revolving fund mechanism for the funding of parking facilities, to which parking facility appropriations and any parking fees are to be directed, is described. However, this funding mechanism has not been followed in the appropriations process.

Since 1972, two VA construction accounts have provided the funding for parking structures. Under this appropriation structure, construction or alteration of parking projects of $2,000,000 or more are funded from the Construction, Major Projects Appropriation, while projects costing below $2,000,000 are funded from the Construction, Minor Projects Appropriation. The maintenance and operation costs associated with parking facilities are funded from the Medical Care

Appropriation. For several years, funds for parking facility purposes have been appropriated to these three accounts instead of a parking revolving fund.

This appropriation structure has proved to be an effective method of providing parking on a nationwide basis. We are concerned that establishment of this funding mechanism, i.e., the parking revolving fund, as the sole funding source for operations, maintenance and acquisition of all parking facilities would impose an unnecessary administrative burden with little benefit for the time invested. As proposed by this bill, the fund would be activated subsequent to September 30, 1986, thereafter necessitating the establishment of a separate accounting system for parking projects wherein all the costs of a project associated with parking would be segregated and prorated accordingly. Such costs typically include: security, utilities, supplies, maintenance, etc. The maintenance of such an account requires a considerable time investment. It would also create a confusing mixture of accounts. For instance, how do you separate a garage structure that is part of a new building in terms of which account pays for what? Furthermore, the establishment of a parking revolving fund may in fact detract from the provision of parking facilities if this approach is not followed in the appropriation process.

We would favor, an amendment to section 5009, however, to permit the depositing of parking fees into the miscellaneous receipts of the Treasury. This approach would not require a significant change in the funding and management of parking facilities and would still allow for the recoupment of parking fees, the purpose of this legislation.

(Mr. Chairman, Mr. Vogel will now present the VA's views on a number of other proposals under consideration this morning.)

Mr. Chairman, the VA strongly supports the concept of legislation which would grant a cost-of-living increase for disability compensation, DIC, and the associated benefits enumerated in title I of S. 2422, to help offset the erosion of purchasing power resulting from increases in consumer prices. Under the bill, the rate adjustments would be keyed to an anticipated 3.4 percent rise in the consumer price index (CPI). The adjustments, like Social Security and VA disability pension adjustments, would be effective December 1, 1986. Under section 108(a) of the bill, the Administrator would be directed to compute alternate rate increases in the event the Social Security cost-of-living increase for December 1, 1986, were to be other than 3.4 percent. We support, as we have inthe past, a percentage increase for VA disability compensation and DIC rates equal to that required by law for Social Security recipients.

Title II of S. 2422 would modify certain procedures relating to VA's acquisition of foreclosed property under the home loan guaranty program, by providing the Administrator authority not to acquire certain properties which would be difficult to sell.

Under current law, a loan holder must notify VA before foreclosing a guaranteed loan. VA then determines the net value of the security property. The term "net value" means the fair market value of the property minus the projected costs to the Administrator of acquiring and disposing of the property. In most cases, VA calculates such costs at 10.5 percent of the property's fair market value.

If the property's net value exceeds the unguaranteed portion of the loan, and the holder acquires such property at the liquidation sale for the lesser of the veteran's total indebtedness or the property's net value, the holder may convey the property to the Administrator.

Under the bill, a loan holder would not be permitted to convey the property to VA unless the Administrator determines that the property can be sold within 1 year at an "economically advantageous" price. The criteria to be used by the Administrator in making this determination are:

a. the size of VA's property inventory;

b. current and projected real estate market conditions; and

c. current and projected economic conditions

in the general area where the property is located. The formula currently contained in the law to determine whether the property may be conveyed to VA would be used only after the Administrator determined the property could be sold under the conditions described in the bill.

At certain times, in some parts of the Nation, it is extremely difficult to sell properties. Currently, for example, areas such as Houston, Texas, which are highly dependent on the oil and gas industry, fall into this category. In those places, VA has attempted to take the poor market conditions into account in appraising property. Nevertheless, properties may sell very slowly, even at depressed market values. Therefore, some flexibility to decline to accept properties which cannot be sold within a reasonable time period may be useful.

Accordingly, VA has no objections to the basic purpose of this measure. We have technical problems with two features of the bill as currently drafted, however.

Under current law, decisions on whether or not to acquire the property are based on readily ascertainable factors, i.e., the property's market value and VA's property management costs. The bill would add considerations which are not more than guesses as to how real estate market and economic conditions may develop within the next year. We would be pleased to work with your staff in developing more manageable criteria.

Our second concern is the computation of the veteran's debt. Under current law, the amount of VA's guaranty claim payment becomes a debt owing to the Government by the veteran. When the property's net value exceeds the unguaranteed portion of the loan, VA specifies a minimum amount, based on the value of the security, which the holder must credit to the veteran's debt following the liquidation sale. Therefore, the veteran's debt takes into account the value of the property.

Under the bill, when the holder would not have the election to convey the property to VA, we could not establish a minimum credit. In most such cases, we expect that the holder would bid the minimum amount permitted under State law. Accordingly, VA's claim payment and the veteran's debt would be increased, and would not fairly reflect the property's value.

We would be pleased to work with your staff in drafting a technical amendment to adjust the veteran's debt in such cases.

Title III of S. 2422 contains three provisions other than the parking fund proposal Dr. [illegible] has already discussed. The first of these--section 301--would amend section 3101 of title 38 to permit the Department of Defense to recover overpayments of military retired pay and retainer pay and delinquent Survivor Benefit Plan (SBP) and Retired Serviceman's Family Protection Plan (RSFPP) premium payments from VA disability compensation and pension. Overpayments frequently occur due to the concurrent eligibility of many veterans for dual DoD and VA benefits. Premium arrearages for SBP and RSFPP separately cause serious problems for DoD's administration of the coverage. DoD supports legislation to relieve these problems. Section 301 would enable the efficient and equitable recovery of these targeted overpayments, as well as collection of delinquent premium payments.

The second provision of title III, section 302, would require a greater degree of accountability on the part of fiduciaries. Section 3202(b) of title 38 presently authorizes the Administrator to require, from fiduciaries appointed or recognized by the VA, accounting of the uses of VA benefits for their wards. The law, however, is unclear about the Administrator's authority to require the fiduciary to furnish information concerning other, health income and assets of the beneficiary of which the fiduciary has knowledge or control. Some fiduciaries decline to furnish such information. We believe VA oversight of proper use of benefit funds would be significantly enhanced by clear authority to require full disclosure. Section 201 would grant this authority. Although we cannot point to significant savings that would result, we believe this change is important to our service mission and would reduce opportunities for misappropriation and fraudulent activities by fiduciaries.

I would also like to comment briefly on section 301 of S. [illegible]. In order to improve the VA's delivery of services and achieve a more appropriate organizational alignment, the Administrator, on February 5, 1986, notified Congress that he intended to implement an administrative reorganization within VA Central Office which would involve the transfer of two functions from the Office of Administration. Specifically, the [illegible] [illegible] [illegible] ([illegible]) Program would be transferred to the Department of Veterans Benefits (DVB) and the Audio Visual [illegible] Service ([illegible]) would be transferred to the Office of the Associate Deputy Administrator for Public and Consumer Affairs.

The [illegible] Program [illegible] the [illegible] of [illegible] [illegible] [illegible] services through the [illegible] of [illegible]. This is a benefit service rather than an administrative service and, therefore, should be in DVB, which is responsible for the delivery of nonmedical benefit services.

The AVS provides audiovisual support services for various activities throughout the VA. This transfer will help consolidate the VA's outreach and public affairs activities in one organizational location. Consolidation will achieve a more integrated approach to the VA's audiovisual activities and enhance compliance with policy, cost-effectiveness, and the quality of product.

In each instance, the program personnel (approximately 7 FTEE and 32 FTEE, respectively) and associated budget resources also would be transferred. The costs associated with the transfer of these functions are insignificant.

As you are aware, because of section 210(b) of title 38, the Agency will have to wait until October 1, 1986, to implement this reorganization unless Congress legislatively waives the waiting period. We requested such a waiver in our letter of February 5 in order to allow us to effect these administrative efficiencies in a more timely fashion. This section would provide that waiver, and we, therefore, fully support this section.

We would note that the necessity of reporting and deferring this minor reorganization, involving the transfer of only about 39 FTEE, in order to comply with section 210(b), demonstrates how this statute denies the Agency the administrative flexibility to promptly restructure operations when necessary to better serve veterans. In this regard, on April 29, 1985, the Agency sent draft legislation to the President of the Senate which would repeal these "report and wait" requirements, but the legislation has not yet been introduced. We strongly urge the repeal of section 210(b)(2).

Another bill under consideration today, S. 2168, would add two enumerated disabilities to those currently listed in section 312(b) of title 38 as presumptively service-connected for certain former prisoners of war. The conditions to be added are frostbite residuals and traumatic arthritis. We question the need for this legislation, since we have no reason to believe that former POWs with such disabilities are being denied benefits. It should be noted as a technical matter, however, that inclusion of the phrase "incurred while interned as a prisoner of war" in the arthritis clause would appear to require just the sort of evidentiary showing that section 312(b) was enacted to avoid. Indeed, any claimant satisfying the requirements of this clause would meet the criteria for basic service connection under section 310, thereby leaving the new clause as a redundancy.

The next bill I would like to discuss is S. 2304, which would provide a 3-year extension of the period of time during which veterans readjustment appointments may be made.

The VA strongly supports an extension of the Veterans Readjustment Appointment (VRA) authority. The VRA has been an efficient and effective method for employing Vietnam era veterans (VEV's). At VA, we have appointed more than 85,000 VEV's under the VRA authority in a wide variety of occupations ranging from Veterans Claims Examiners to Police Officers. To this end, the VRA authority has provided VA and other agencies an expedited and simplified method for staffing vacancies, thus saving recruiting time and maintaining a high quality of job candidates. The extension would allow us to employ additional VEV's, including those who are disabled.

It is noteworthy that VRA appointments help address veteran unemployment without significant cost. Extending the veterans readjustment appointment authority over the 3-year additional period is essentially a cost-free way of helping veterans complete their readjustment to civilian life. We believe that extending this authority would have no budgetary impact on the VA.

Mr. Chairman, this concludes my remarks. I would be pleased to answer any questions the Committee may have.

MAINE VETERANS HOME

CONY ROAD, RFD #2, BOX 901 Tel: (207) 622-2454 AUGUSTA, MAINE [illegible]

## MAINE VETERANS HOME TESTIMONY ON S. 1536

Mr. Chairman, Distinguished Members of the Senate Veterans' Affairs Committee, the Maine Veterans Home thanks you for this privilege to express support for S. 1536, a technical amendment to Title 38 of the United States Code:

> "to provide that per diem subsidies paid by the Veterans
> Administration for the care of veterans in State homes shall
> not be used to offset payments that are made under the medicaid
> program for the purpose of assisting eligible veterans."

More than 20 years ago, in 1964, the 88th Congress passed the State Veterans Home Construction Grant Program, a sharing by Federal and State governments of both construction and operational costs of State Veterans Homes. Shortly thereafter the 89th Congress passed the Medicare-Medicaid Program, the Medicaid portion of which is another Federal-State cost sharing program which today is the primary source for funding the operational costs of nursing homes in this country.

These two acts of Congress come in conflict with one another when a State Veterans Home, such as the Maine Veterans Home, elects to become a certified Medicaid nursing home. One law, Section 641 of Title 38, United States Code, provides through the Veterans Administration, a per diem of $17.05 for each day an eligible veteran receives care in a nursing home unit of a State Veterans Home. The other law, Section 1902 (a) (26) of Title XIX, of the Social Security Act, has been interpreted by the General Counsel of the Health Care Finance Administration of the U. S. Department of Health and Human Services to the effect that the VA per diem is used to replace Federal and State Medicaid dollars financing nursing home units of State Veterans Homes certified in Federal-State Medicaid programs. Thus, in such circumstances, the VA per diem does not benefit the veteran. Instead, the VA appropriation merely replaces the Federal and State share in the cost of the Medicaid program. The General Counsel's decision results in a unique form of Federal revenue sharing, without benefit to the veteran.

The Maine Veterans Home does not believe that the result described above was the intent of Congress, either in the legislation creating the VA per diem or in the Medicaid third-party liability statutes.

The Maine Veterans Home believes that Congress clearly intended the VA per diem to be used for the benefit of veterans in State Veterans Homes. The conflict arises when the HCFA General Counsel states that Medicaid regulations define a third party as: "any individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease, or liability of an applicant or recipient." The Maine Veterans Home believes that this Medicaid statute was directed at collecting private or group health insurance, workers compensation or liability claims on behalf of a Medicaid client, before using Medicaid dollars. The Maine Veterans Home does not believe that it was the intent of Congress to use the VA per diem as "first dollar" payment in supporting the worthwhile concept that the Medicaid program should be the payer of last resort.

Favorable consideration of S. 1536 by this Committee and the 99th Congress will result in directing the VA per diem to benefit the veteran, rather than replacing Federal-State Medicaid dollars. If this proposed amendment is enacted, States would no longer be able to replace State tax dollars with the VA per diem and would be required to meet the State share of the Federal-State Medicaid program with State appropriations, rather than in part, with the VA per diem.

In this fiscal year, the Maine Veterans Home will receive approximately $450,000 in VA per diem on behalf of Medicaid eligible veterans. The Federal-State Medicaid sharing in Maine is approximately 2/3 Federal to 1/3 State. Under the current ruling by HCFA, the State takes the

$450,000, uses 1/3, ($150,000) to replace the State share of the Medicaid payment, and uses the other 2/3, ($300,000) to offset the Federal share of the Medicaid payment.

From a common sense point of view, it does not seem prudent to appropriate funds to one Federal agency, the Veterans Administration, for the purpose of providing a benefit to veterans, merely to have such funds used to replace Federal and State funds in another program, Medicaid, without any benefit to the veteran for whom the funds were originally intended.

Medicaid eligible veterans at the Maine Veterans Home are entitled to Medicaid benefits, even if the Home was not in existence. Therefore, it seems reasonable that the VA per diem be used to further enhance the quality of care available to the veteran, and not merely subsidize both the Federal and State share of the Medicaid program.

Passage of this legislation will allow States such as Maine, and other States who are considering the initial construction of State Veterans Nursing Homes, an opportunity for financing the capital and operational costs of such homes which will provide a higher quality of care for Medicaid eligible veterans than that provided at any other Medicaid funded nursing home. The combination of VA per diem and Medicaid financing, in the long run, is the least costly means by which Federal and State Governments can meet the long term care institutional needs of our aging veteran population. Attachment #1 lists Advantages of Enactment of S. 1536.

Thank you, Mr. Chairman, members of the Committee, for your consideration of these comments.

William J. Carney

William J. Carney
Administrator
Maine Veterans Home
May 20, 1986

## ADVANTAGES OF ENACTMENT OF S. 1536

A measure of the cost effectiveness of the State Veteran's Nursing Home program is seen in the Veterans Administration December 1985 Quarterly Cost Report, from which the following data is extracted. A day of care in a VA Nursing Home bed costs 7 times more than the cost of care in a State Veterans Home nursing care bed. Community Nursing Home beds cost almost 4 times more.

| LOCATION OF NURSING HOME CARE | AVERAGE DAILY CENSUS | AVERAGE COST PER DAY |
|---|---|---|
| VA Nursing Home Beds | 10,254 | $119.42/Day |
| Community Nursing Home Beds | 11,609 | $ 66.76/Day |
| State Veterans Nursing Home Beds | 7,916 | $ 17.05/Day |

If one accepts the premise that State Veterans Home nursing care beds are the most cost effective means of delivering institutionalized long term care to the aging veteran population, it follows that there are economic advantages to the Federal Government to stimulate the development of new State Veterans Home nursing care units.

The Maine Veterans Home is very pleased and proud of the recognition of the State Veterans Home program in the Veterans Administration Budget for Fiscal Year 1987. The requested amount of $42.4 million is twice the amount approved in FY 86. In a year of budget constraints, this appropriation request is strong testimony to the Veterans Administration opinion of the quality and cost effectiveness of the State Veterans Home Program.

The impact of the $42.4 million budget request shrinks in magnitude when compared with the $170.4 million (10/31/85) list of eligible VA grant requests for State Veterans Home construction funds. Consider how

ATTACHMENT # 1

frustrating it is for States who want to build new homes but must wait 5 years after a preapplication has been accepted.

S. 1536 is a request to provide States the opportunity for an optional source of funding for capital and operational costs of State Veterans Home nursing care units. If S. 1536 is enacted, the current list of construction grant requests may be reduced in size and future lists may be shorter. The needs of our aging veteran population will be met sooner.

A major question in the minds of State Legislators, where a State Veterans Nursing Home is just starting, or in States where homes are only now being considered may be: What is the least costly way to build and operate a State Veterans Home nursing care unit? An answer for some states, particularly States with a high Federal to State Medicaid match is contained in enactment of S. 1536 which will:

1. Provide an opportunity for States to use a more economical financial mechanism in order to provide the 35% capital construction match in the VA Construction Grant Program.
2. Allow States the opportunity to use the Federal-State Medicaid Program to fund operational costs for Medicaid eligible recipients, while providing the higher quality of care required by the Veterans Administration. This is a less costly option for States than the use of State General Fund Appropriations.
3. Permit States the opportunity to realistically consider the use of conventional financing, rather than the VA Grant Program for new construction or renovation of State Veterans Nursing Home beds.

ATTACHMENT # 1

*Statement of*

# *The American Legion*

**1608 K STREET, N. W.**
**WASHINGTON, D. C. 20006**

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

on

VETERANS DISABILITY COMPENSATION,
HEALTH CARE, AND OTHER ISSUES

**MAY 20, 1986**

Mr. Chairman and Members of the Committee:

We appreciate this opportunity to offer The American Legion's views on the several proposals relating to veterans benefits and services that are under consideration during today's hearing. The bills are not listed in numerical sequence, but instead with respect to the intent of each measure.

S.2422 - Title I of this proposal would provide a 3.4 percent cost-of-living adjustment, effective December 1, 1986 for disability compensation paid to veterans for disabilities and diseases incurred while serving on active military duty; and dependency and indemnity compensation paid to survivors of veterans who died while serving on active duty, or as a result of a service-connected illness or injury. In addition, the 3.4 percent COLA would apply to the additional allowance paid to recipients of compensation and DIC for their dependents; and in the annual clothing allowance paid to veterans who require the use of prosthetic devices as a result of their service-connected disabilities.

Section 108 of this proposal would provide that if an increase that is different than 3.4 percent is provided Social Security recipients and veterans in receipt of nonservice-connected disability pension (which is indexed to the increases in Social Security), the Veterans Administration will administratively recompute the COLA to provide the same increase for compensation, DIC and related benefits. If adjusted under this section, in the computation of the rates, amounts of $.50 or more would be rounded to the next higher dollar; and amounts of less than $.50 would be rounded to the next lower dollar amount.

For those disabled veterans, dependents and survivors who receive these benefits to keep pace with the increasing costs of goods and services, it is imperative that the rates payable under the disability and death benefits must respond to cost-of-living increases. It has long been the policy of The American Legion that these COLAs should, at least, be consistent with increases in the Consumer Price Index.

We are opposed to the permanent indexing of compensation, DIC and related benefits. However, since section 108 would, in our interpretation, only apply to the increases effective December 1, 1986, we would not object to this proposal.

Section 201 of S.2422 would prohibit VA from acquiring title to foreclosed properties unless the Administrator determined that the property could be disposed of within one year of acquisition and unless the Administrator further determined disposal of the property would be accomplished in a manner economically advantageous to the government. The Legion is keenly aware of the problems VA has had in managing its large portfolio of foreclosed and acquired properties. Most of the acquisitions having bloated this portfolio in recent years are the result of the nation's most recent recession. Since the recession has ended, however, VA has continued to acquire large numbers of properties particularly in areas of the country where either the effects of recession linger on or where dramatic economic changes have recently been highly disruptive. In the first instance, parts of the nation traditionally engaged in certain heavy industries have yet to, and may never, rebound from recession. In the latter instance, recent precipitous reductions in the value of oil have thrown other areas of the country into economic chaos. The result in either case has been high rates of foreclosure and subsequent declines in property value.

When VA acquires these foreclosed properties and is unable to swiftly market them, it is often compelled to sell these properties for far less than the cost of acquiring them in the first place. For this reason, the Legion is inclined, albeit cautiously, to support the intent of this adjustment in the management of the VA home loan program.

The basis of our reservations, however, stems from what effect this adjustment might have in the lending community and ultimately on the ability of veterans to secure mortgages guaranteed by VA. Before this part of S.2422 is approved either by this Committee, the Senate or the Congress as a whole, there must be assurances given that no unintended ill affects will result. Will lenders, for example, abandon the VA program in the absence of assurances that VA will acquire foreclosed properties that genuinely can be marketed within a year at a price beneficial to the government? Will OMB use this adjustment in the law to force VA to refuse the acquisition of any property under any circumstances? In the absence of any specific criteria setting forth the standards by which the Administrator is required to make determinations of sales price and marketability within a one year period, the Legion is constrained from supporting anything beyond the intent of this amendment.

In our view, a more appropriate approach to disposal of inventoried VA property was provided for in housing legislation approved by this Committee and the Senate last year. Under those provisions, VA would have been given the authority to undertake a pilot program of contracting out the property disposal portion of the program.

Another aspect of this adjustment in the home loan program that concerns us is the question of whether or not VA has or will have sufficient numbers of home loan personnel to properly determine how long it will take and at what price foreclosed properties can be marketed. Under personnel reductions since 1979, the Department of Veterans Benefits (DVB) has already lost 5,476 FTEE. Since January of this year, DVB has lost approximately 25 percent of its home loan officers to attrition, early retirements, Gramm-Rudman reductions and a hiring freeze.

Given today's low interest rates and the release of pent-up demand for housing these lower rates have generated, we strongly suspect personnel resources that might otherwise be available to manage and market foreclosed properties are being directed to other duties. As long as interest rates are projected to remain low, VA's home loan program can be expected to be hard pressed to fulfill its already assigned missions without further augmentation.

Title III of S.2422 would make amendments to other veterans programs. Section 301 would amend section 3101 of title 38, to authorize the Veterans Administration to collect overpayments from the disability compensation of military retirees who have waived their retirement pay in order to receive the compensation. This provision would establish a mechanism to recover debts owed the service department by the retiree in those cases where no money is being paid the individual by the military service involved. In addition, it would allow deductions for the survivor benefit plan or retired servicemember family protection plan to be made from VA compensation.

With respect to the debt collection, the requirements for notice and due process before an overpayment may be collected would not be changed.

The American Legion has no objection to these provisions.

Section 302 would amend section 3202 of the title by requiring a complete accounting to the Veterans Administration for the funds of an incompetent veteran by the fiduciary responsible for managing the veteran's funds on his or her behalf.

According to the introductory language, the purpose of this proposal is to ensure the funds of an incompetent veteran are expended on the veteran's behalf, and the Legion would certainly not object to that intent.

Section 303 of this measure would amend section 5009 of the title by requiring the Veterans Administration to establish a schedule of reasonable parking fees at medical centers where a garage is constructed, altered or acquired after September 30, 1986, if the cost exceeds $500,000.

Discretionary authority to charge parking fees, currently set forth under section 5009, would continue at all other VA medical centers. Once a schedule of fees is established under this proposal, collection would be required for employees, visitors and all other individuals except veterans who are transported to or from a VA facility for examination or treatment. For those VA facilities where fees would become mandatory after September 30, 1986, the parking fees would have to be sufficient at a minimum, to cover the operation and maintenance costs of all parking facilities at the medical center, and the funds collected would be placed in a revolving fund for this purpose, as well as for the acquisition, construction or alteration of additional parking facilities.

Under this proposal, the restriction that currently exists on authorization of appropriations for construction or alteration of garages or parking lots costing over $2 million would be negated. However, any expenditure from the revolving fund in excess of $2 million would be subject to the requirements for appropriations for major medical facility construction set forth under section 5004 of title 38. After September 30, 1986, VA would only be permitted to use funds from the revolving fund for constructing, altering or acquiring facilities for parking, and all expenditures of revolving fund resources would be subject to approval by an Appropriation Act.

Mr. Chairman, as we have stated on previous occasions, at times the issue of the provision of parking at VA medical care facilities is given low priority. Some feel that it is a small concern in the overall scenario of providing medical care to veterans. However, The American Legion does not share that opinion.

In many instances, particularly in urban areas, adequate parking facilities can make the difference as to whether or not medical centers are able to recruit and retain qualified medical care professionals. Equally as important, the availability of facilities at which to park an automobile may be the determining factor as to a veteran's ability to seek and receive needed medical treatment.

This measure would provide the basis for funding needed garages or parking lots, through a revolving parking facility fund. In addition, the language contained in section 303 of the bill would exclude veterans seeking treatment from the mandatory parking fees that would be applied commencing October 1, 1986, and this is unquestionably important. The American Legion would not support any initiative that would assess a parking fee on veterans who travel to a VA medical care facility for hospitalization or treatment. The proposal also addresses in part a concern that we raised when questioned as to our views on the general concept of VA parking fees during this Committee's April 10 medical construction hearing. We pointed out that exercise of the authority to charge for parking on a system-wide basis would be unacceptable since many medical centers are located in rural or remote areas where there is a surplus of parking space. S.2422 would continue the existing discretionary authority to charge reasonable parking fees at medical centers other than those building new parking facilities.

Given the fact that under the prevailing sentiment toward expenditures for parking facilities expressed by some key members of Congress, this may well be the only solution for providing badly needed parking areas at some VA medical centers. Therefore, we generally support the intent of section 303, although we are somewhat concerned about the economic impact that parking fees may have on some VA employees, particularly those in the lower grade levels.

Section 304 would waive the reporting requirements of section 210(b)(2) of title 38, allowing the Veterans Administration to proceed with the transfer of the staff administering the Presidential Memorial Certificate Program to the Department of Veterans Benefits, and the staff of the Audio Visual Service to the Office of the Associate Deputy Administrator for Public and Consumer Affairs. The transfers would involve no changes in duty station, as the 39 individuals involved are now and will remain in VA Central Office.

The American Legion has no objection to this proposal.

Mr. Chairman, the next three bills - S.2186, S.2187 and S.2423 - all would exempt certain Veterans Administration benefits and programs from sequestration under part C of the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman). We shall list the provisions of each measure and then offer comment on them collectively.

S.2186 - would exempt the following programs:

(1) Patient benefits which, under the compensated work therapy program are payable from the Veterans Administration Special Therapeutic and Rehabilitation Activities Fund to veterans who have a service-connected disability.

(2) Benefits under chapter 21 of title 38, relating to specially adapted housing for disabled veterans.

(3) Burial benefits for veterans who die as the result of a service-connected disability.

(4) Assistance under chapter 31 relating to training and rehabilitation for veterans with service-connected disabilities, but only with respect to those rated 50 percent or more.

(5) Automobiles and adaptive equipment for certain disabled veterans and members of the Armed Forces.

S.2187 - would exempt the following programs:

(1) Chapter 21 of title 38, related to specially adapted housing for veterans with certain service-connected disabilities.

(2) Burial and funeral benefits in the case of veterans who die as a result of a service-connected disability.

(3) Vocational rehabilitation and related benefits under chapter 31 for certain veterans with service-connected disabilities.

(4) Educational assistance for the dependents of veterans with permanent and total service-connected disabilities, and for the survivors of those who die as a result of a service-connected disability, as set forth in chapter 35 of the title.

(5) Automobiles and adaptive equipment for veterans with certain service-connected disabilities.

S.2423 - would exempt the following programs:

(1) Burial benefits in the case of veterans who die as a result of a service-connected disability.

(2) Specially adapted housing and mortgage protection life insurance.

(3) Vocational rehabilitation and related benefits under chapter 31 of title 38.

(4) Survivors and dependents educational assistance under chapter 35 of the title.

(5) Automobiles and adaptive equipment under chapter 39.

(6) Insurance loans under NSLI and USGLI policies administered by VA.

(7) Patient benefits payable from the Special Therapeutic and Rehabilitation Activities Fund to veterans in the compensated work therapy program.

(8) Canteen Service revolving fund.

(9) VA home loan guaranties.

According to the introductory language accompanying S.2423, the bill also contains a provision designed to prevent the exemption of any of the service-connected benefits from resulting in a disproportionate cut in the other benefits paid from the same account as the protected benefit. Thus, since the entire account would not be exempted and since Gramm-Rudman generally requires uniform percentage reductions on an account-wide basis, the bill would preclude the exempted benefits from being counted for purposes of computing the amount of any sequestration of the account.

The American Legion supports the intent of these three legislative initiatives. Having been provided options in the latitude of the proposed exemptions for benefits payable from the Special Therapeutic and Rehabilitation Activities Fund; and under the Vocational Rehabilitation Program, through differences in the language contained in S.2423 as compared to S.2186, we support the provisions of S.2423 as they would obviously serve to protect the interests of a larger number of veterans who are in need of and benefit from both of these important programs.

Mr. Chairman, as you are well aware, each of the programs contained in the three above - mentioned bills were affected by the sequestration order that was effective March 1, and remains in effect until September 30, 1986. Available figures reflect the following reductions in the identified direct veterans benefits as the result of PL 99-177:

Automobiles and Adaptive Equipment - The maximum automobile allowance payable will be reduced 8%. An 8% reduction also will be made in amounts authorized as reimbursement for automobile adaptive equipment. Payments authorized between March 1 and · September 30, 1986, will be affected, regardless of when original eligibility was established.

Burial Benefits - A reduction of 7.75% will be made in allowances payable for service-connected and nonservice-connected burial allowances, the plot/interment allowance, and for headstone reimbursement. Payments authorized between March 1 and September 30, 1986, will be affected, regardless of when the veteran died or when the claim was received. Transportation costs, when payable, will not be subject to the 7.75% reduction.

Educational Assistance - All educational assistance benefits to eligible veterans training under the Vietnam Era G.I. Bill (Chapter 34), and to eligible persons training under the Survivors' and Dependents' Educational Assistance program (Chapter 35) will be paid at rates 8.7% below those stated in title 38, United States Code. The 8.7% reduction will be applied to all money obligated between March 1 and September 30, 1986.

Insurance Policy Loans - Effective April 1, 1986, and continuing through September 30, 1986, the percentage of reserve value (i.e., cash value) that a policyholder under the United States Government

Life Insurance (USGLI), Veterans Reopened Insurance (VRI), and Service-Disabled Veterans Insurance (S-DVI) programs may borrow against is reduced from 94 percent to the following levels:

| Program | % of Reserve |
|---|---|
| USGLI | 10 |
| VRI | 59 |
| S-DVI | 76 |

These limitations apply only to the issuance of new policy loans under the USGLI, VRI, and S-DVI programs. Existing loans under these programs remain unchanged, but policies with loans which exceed the above limits will have no further loan value until the loans are reduced below the applicable limit. Insurance policies under the National Service Life Insurance (NSLI), Veterans Special Life Insurance (VSLI), and the Veterans Insurance and Indemnities (VI&I) programs are not affected by this change. The policy loan interest rate will remain at 11% percent for all programs except USGLI, which is statutorily fixed at 5 percent.

Loan Guaranty - Public Law 99-255 increased the guaranteed loan limitation amount. There is no change in Loan Guaranty benefits.

Specially Adapted Housing Grants - The VA will reduce by 8% the amount of the grant otherwise computed for specially adapted housing or special housing adaptations for severely disabled veterans. The 8% reduction will be applied to applications approved during the period beginning on March 1, 1986, and ending on September 30, 1986.

Vocational Rehabilitation - VA payments of tuition, books, supplies and other rehabilitation services will not be affected by Public Law 99-177. However, subsistence allowance payments to veterans in the Vocational Rehabilitation program will be reduced 13.1% for all money obligated between March 1 and September 30, 1986. The maximum amount which may be advanced from the revolving fund, employment adjustment allowances, and special transportation allowances also are being reduced 13.1%.

Each of these benefits, as well as the others that are included in the instant legislation, has a distinct purpose, has been adequately justified as meeting a legitimate need of the veteran population, and so far as The American Legion is concerned, should never have been included among the Federal benefits that are subject to sequestration under the provisions of Gramm-Rudman.

One important program that is not included in S.2186, S.2187 or S.2423 for exemption from the Presidential sequestration orders, but which The American Legion strongly feels should be, is the educational assistance allowance under chapter 34 of title 38. The 8.7 percent reduction in the rates will undoubtedly have a dilatory effect on the educational goals of most Vietnam veterans who are entitled to receive these readjustment benefits. Those veterans who depend entirely on this stipend could be forced to discontinue their program of education or training altogether.

The Vietnam War officially ended eleven years ago, and the majority of veterans who desired to continue their educations or receive specialized training have already done so. The Vietnam veterans who are now pursuing their education and training under chapter 34 are, for the most part, those who have undergone readjustment problems following separation from military service, or who have been faced with severe economic problems because of unemployment and other factors.

The American Legion is extremely concerned about the impact that the reduction in funding in education benefits will have on the ability of these veterans to pursue the career development needed to enter the employment field in competition with those individuals who did not serve in the Armed Forces.

Mr. Chairman, The American Legion petitions this Committee to take action to correct this inequity by including the educational assistance program under chapter 34 among the other important benefits for which exemptions from the provisions of Gramm-Rudman are being sought.

In addition to the impact that this deficit control measure is having on direct benefits, The American Legion is concerned about the effect of fund losses on the operations of the Department of Veterans Benefits. Therefore, we are in the process of surveying our Department Service Officers in order to collect data reflecting the ability, or lack thereof, of the Regional Offices to provide quality service in timely fashion to VA beneficiaries. Although we are continuing to receive this information from the field, preliminary reports indicate the March 1 sequestration is causing severe personnel losses at all Regional Offices.

As we have pointed out to this Committee on numerous occasions, it is a fact that the Department of Veterans Benefits has been losing personnel consistently for the past several years. Since FY 1979 the average employment has been reduced by 5,476 FTEE, including 918 that were cut in the current fiscal year. Of the 918, Gramm-Rudman accounted for 431 of those positions lost this year.

Based on the information we are receiving from the Department Service Officers, the combination of personnel losses, early retirements and the hiring freeze are causing innumerable problems in every single Regional Office, and we anticipate an immediate deterioration in the quality and timeliness of the delivery of benefits and services to veterans. The only possible remedy to this deplorable situation is Congressional intervention, and we urge this Committee to undertake a review of the impact of the administrative cost reductions required by Gramm-Rudman on the Department of Veterans Benefits.

The next measure, S.2168, would amend section 312(b) of the title to include organic residuals of frostbite, and arthritis resulting from trauma incurred while interned as a prisoner of war, among the presumptive diseases for which service connection may be granted in the case of a former POW under certain circumstances.

The American Legion supports the intent of this bill. However, its enactment would only partially satisfy our mandate as set forth in Resolution No. 20 of the 1985 National Convention titled "The American Legion Policy on Presumptive Disabilities of Former Prisoners of War". Resolution No. 20 places the Legion in a position to support legislation to amend section 312 in such a way as to provide presumptive service connection for the following conditions in the absence of demonstrable intercurrent disease or injury:

1. Hepatitis or other infectious diseases of the liver;
2. Organic residuals of hypothermia, e.g., trench foot, immersion foot or hand, Raynaud's Disease;

3. Arthritis;
4. Peripheral neuropathy;
5. Chronic pulmonary disease (where there is history of forced labor in mines during internment);

The resolution also mandates the Legion to support the amendment of section 612(b)(1)(G) of the title to reduce from 60 days to 30 days the period of time a former prisoner of war must have been detained or interned in order to be eligible for dental treatment by the Veterans Administration.

Legislation, S.2304, introduced by Senators Cranston, Matsunaga, DeConcini, Mitchell and Rockefeller would extend the Veterans Readjustment Appointment authority (VRA) for three additional years. This program is currently scheduled to expire on September 30, 1986 unless reauthorized. The American Legion urges the members of this Committee not having already cosponsored this measure to join us in supporting this extension with an additional modification. Specifically we recommend current VRA program education level limitations be relaxed.

Under the law as it is presently written, no veteran may participate if he or she has attained a level of education exceeding 14 years, the equivalent of two years of college. In the Legion's view, opening participation in this program to veterans, for example, with no more than a college degree - the equivalent of 16 years of education - would enhance federal job opportunities for veterans without compromising the readjustment purposes of VRA.

By now it is a well known fact that Vietnam era veterans entered college, by reason of their service, later than their nonveteran peers or had their training careers interrupted because of financial, family or personal readjustment problems. This later start has had the affect of giving nonveterans who were educated earlier a significant edge. For many, entry level qualifications were increased beyond those applied to nonveterans by the time veterans entered the job market. For others, employment in well paying industrial jobs following completion of training was secured but many of these industries are now in permanent decline. A relaxation of the education limitation would accommodate some of these currently unemployed or underemployed veterans.

An additional reason for supporting this modification was evident at a March 20, 1986 hearing held by the House Veterans Affairs Subcommittee on Education, Training and Employment. During that Committee's consideration of extending VRA, the question of why so many agencies other than VA fail to exercise this program's optional authority arose. Witnesses from the Departments of Education and Health and Human Services responded by stating that the operations of those agencies were skewed in favor of more highly educated employees. Under the circumstances, restricting VRA participants to 14 years of education has effectively frozen many otherwise promising college graduate veterans out of these agencies.

Mr. Chairman, the next three bills address a broad range of issues relating to veterans' health care.

S.2388 - is titled the "Veterans' Administration Health-Care Programs Extension and Improvement Act of 1986".

Section 2 of the bill would amend section 218(b) of title 38 by authorizing the Veterans Administration to enter into agreements with State and local governments that would enable VA police officers to enforce the traffic laws of those political jurisdictions. This would be accomplished by empowering the VA police officers with the authority to issue citations for violations of these laws that occur on VA property.

We understand that under current law the VA can only enforce traffic laws on VA property by issuing regulations and then securing the agreement of the U.S. District Court to issue rules of the court incorporating the VA regulations. Once accomplished, it becomes possible to refer violations of the VA regulations to the local office of the U.S. Attorney for further action. This appears to us to be an unwieldy manner in which to attempt to enforce traffic laws, thus we support the intent of this provision to allow the VA police to directly enforce these laws.

Section 3 of this measure would amend section 601(6) of the title by authorizing the Veterans Administration to furnish services to help a male or female veteran or a male veteran's spouse achieve pregnancy in cases in which the veteran's service-connected disability impairs procreative ability. According to the introductory statement that accompanied this legislation there are a relatively limited number of veterans who would be eligible for these services and an even smaller number who would avail themselves of them.

Obviously, the vast majority of those individuals who would receive this assistance are Vietnam veterans who, without the application of special procedures to overcome the service-connected impairment of their procreative ability, would not be able to parent natural children. In consideration of these circumstances, we support the intent of this section.

Section 4 of S.2388 would amend section 601(b)(B) of title 38 by providing extended eligibility for mental health counseling and related services to those family members receiving counseling, along with the veteran, at the time of the veteran's death. The proposal would authorize VA to continue, for up to six months following the death of the veteran, to provide appropriate mental health assistance to the family members, and The American Legion supports such an extension.

Section 5 would amend section 610(6) of title 38 with respect to eligibility for domiciliary care. As we interpret this section it would merely clarify the language that sets forth the eligibility criteria for domiciliary admissions and we have no objection to such a clarification.

Section 6 of S.2388 would amend section 612A of the title by expanding the eligibility criteria for the provision of readjustment counseling.

This section would make eligible for readjustment counseling services those current members of the Armed Forces, who also served on active duty during the Vietnam conflict. In addition, it would provide eligibility for these services to individuals who served in the Armed Forces after the Vietnam Era, and who were subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in combat during a period of war.

The American Legion views favorably the provision of readjustment counseling to those persons serving on active duty who also served in Vietnam. As far as we have been able to determine, there are few if any readjustment counseling services available in military medical facilities to address problems related to post-traumatic stress disorder, and other readjustment issues. Perhaps more importantly, as we have mentioned in the past, if such counseling programs were available, through the military, it is unlikely that many individuals on active duty would seek assistance from them. Most veterans of Vietnam who have continued their military service are career-oriented senior enlisted personnel and officers who would not jeopardize their future advancement by submitting themselves for treatment of any condition that could be construed as "psychiatric" in their service medical records.

Likewise, we would not object to the extension of eligibility for readjustment counseling to those individuals in service during periods of time and in specific locations in which U.S. Armed Forces were engaged in combat. There is no doubt that the Marines in Beirut, and many of the Army, Navy, Air Force and Marine Corps personnel involved in the invasion of Granada were faced with life-threatening incidents - the precursor of PTSD. Unlike the situation that existed when veterans were returning from Vietnam, much more is now known about the causes, effects, diagnosis and treatment of PTSD. We would hope that the latest group of American troops involved in combat were provided a period of desensitization or decompression, much like that provided the American hostages upon their release from Iran. A program of this nature should alleviate future problems for many of these military personnel.

Section 7 would create a new section 620B in the title that would authorize VA to carry out a three year pilot program of respite care. During fiscal years 1987 through 1989, the VA would periodically provide, for short periods of time, hospital or nursing home care to certain compensable service-connected veterans who are otherwise receiving care at home. Included is a requirement that VA carry out a study of the medical efficacy and cost-effectiveness of furnishing such care, the results of which would be reported to the Committees on Veterans Affairs.

The American Legion is very much in favor of making respite care a permanent program of the Veterans Administration. Respite care is one of the innovative treatment techniques and modalities that can be used to make the VA medical care system more cost-effective, and able to care for the largest number of patients. The trend in modern medicine is to keep patients deinstitutionalized and in a family or community setting as much as possible. This enhances the quality of life provided the patient, and is the most cost-effective method of practicing modern medicine. Equally important with respect to veterans who are terminally ill, respite care is of great help to the family members, as it supports their ability to provide comfort and care during the terminal phase of the illness.

Section 8 would require the VA to conduct a 4 year pilot program at 10 demonstration project sites to evaluate noninstitutional alternatives to institutional care. Through the pilot program, the VA would provide certain veterans with medical, rehabilitative and other health services. In addition, it would provide other health-related services through contract with non-VA entities. Participation in the pilot program would be limited to veterans eligible for and otherwise in need of VA hospital, nursing home or domiciliary care. Priority would be accorded veterans with service-connected disabilities, to veterans age 65 or older, and to veterans who are permanently and totally disabled.

The health and health-related services would be provided through settings such as the veteran's home or a board-and-care home. The goal is to be able to avoid institutional care for the participants in the program.

Each veteran involved in this program would have a VA case manager responsible for the veteran's access to the appropriate combination of needed services such as medical care and health related services.

The total cost of conducting the pilot program is not to exceed 60 percent of the cost that would otherwise have been incurred by VA if the veterans participating in the program had been furnished nursing home care rather than the noninstitutional services.

Mr. Chairman, The American Legion has over the past several years consistently supported the theory of maintaining the veteran patient in the community as much as, and for as long as possible. In our analysis of the VA report entitled "Caring For The Older Veteran" it is pointed out that in looking to the future from the Legion's standpoint, we will have to realize the fact that many more veterans will be receiving health care in community settings under the Veterans Administration's guidance. Cooperative efforts with community programs are already underway to a limited degree. It is important that these efforts be expanded, and that liaisons with community resources that share VA's interest in the aging are maintained. In addition, our analysis of the report emphasizes that alternative care programs featuring noninstitutional care settings must be aggressively pursued to help contain costs.

On a number of occasions during hearings before this Committee, we have stated that it is our intent to encourage both Congress and VA to foster the development and implementation of all of the innovative techniques that can be used to both make the system more cost-effective, and able to care for the largest number of patients. As stated in our comments on respite care, the trend in modern medicine is to keep patients deinstitutionalized and in a family or community setting as much as possible.

Section 9 of this proposal would amend section 621 of the title to eliminate the authority of the Administrator of Veterans Affairs to prescribe limitations on the furnishing of hospital, nursing home and domiciliary care by VA as he deems proper and necessary. We understand that this authority dates from the Economy Act of 1933, and has rarely, if ever, been used.

The American Legion has no objection to repealing this authority.

Section 10 of the bill would amend 38 USC 632 by extending for three years - through FY 1989, the authority for VA to contract with the Veterans Memorial Medical Center in Manila for the care and treatment of United States veterans in the

Philippines; and the authority for VA to make grants of up to $500,000 annually to the Veterans Memorial Medical Center to assist in the replacement and upgrading of equipment and the rehabilitation of the physical plant.

The American Legion has consistently supported these authorizations and continues to do so.

Section 11 of this initiative would amend title 38, section 1520 by making permanent the independent living services and assistance program for severely disabled service-connected veterans for whom the Veterans Administration has determined the achievment of a vocational goal is not reasonably feasible. This program was enacted under PL 96-466 - the law that revised, updated and improved the vocational rehabilitation program under chapter 31 - as a four year pilot program. The purpose of this program is, as its name implies, to provide assistance to these seriously service-disabled veterans in order to enable them to achieve maximum independence in daily living. We understand that although the program is by design a small one as far as the number of participants is concerned, it has proven successful in many cases in instilling a sense of independence, satisfaction and well-being in the veterans involved.

The American Legion feels that the independent living services and assistance program is a worthy one and one that should be continued in order to provide this valuable support to a small number of veterans who have been severely disabled as a result of their service to the nation.

Section 12 would amend 38 USC 5033 to extend the authorization of appropriations for grants to States for the construction, remodeling or renovation of State Home facilities, through fiscal year 1991.

The American Legion is extremely aware of the importance of the services provided by State Homes, in that they have substantially reduced the burden that otherwise would have been borne by the Veterans Administration. We consider this program a wise investment, and when considering the continuing efforts to reduce federal spending, the role of the State Homes becomes even more significant. We strongly urge the extension of this authorization for these reasons.

Mr. Chairman, the next bill under consideration is S.2445, cited as the "Veterans' Health Care Programs Improvements Act of 1986".

Section 2 of this bill would amend section 601 of title 38 by providing the Veterans Administration with the discretionary authority to furnish respite care to chronically ill veterans. Under this proposal, respite care would be furnished by a VA facility on an intermittent or temporary basis to a chronically ill veteran residing primarily at home. The goal is to provide a brief break for the veteran's caregiver or family from the constant, long-term responsibility of caring for the veteran. The purpose of this relief is to provide an incentive for the veteran to continue to reside at home as long as it is feasible.

The position of The American Legion on the importance and necessity of respite care is set forth in our comments on section 7 of S.2388. As stated, we are very much in favor of making respite care a permanent Veterans Administration program, thus we support the intent of section 2 of S.2445.

Section 3 would amend 38 USC 610, by authorizing VA to furnish hospital- based home care, and health related services to certain veterans in their own homes. Under this section, hospital-based home care would be furnished, when medically feasible, to chronically ill veterans otherwise eligible for VA hospital or nursing home care. Medical, rehabilitative, social and nutrition services would be provided in the home setting by an interdisciplinary team under direction of a physician. The bill provides VA with contract authority for the furnishing of these services.

According to the introductory statement addressing this proposal, fewer than one-third of the VA medical centers currently operate a Hospital-Based Home Care program, and that the language of S.2445 would provide VA with the flexibility to contract for these services, as recommended by the VA Geriatrics and Gerontology Advisory Committee in its December 1985 report.

This section would also authorize the Veterans Administration to furnish community-based health-related services to assist veterans eligible for and otherwise in need of community nursing home care. This specifically applies to veterans who because of physical or mental disabilities are unable to perform necessary activities of daily living. Contract authority would be provided for the furnishing of personal care, homemaker, nutrition and transportation services, with priority to be given to veterans who are service-connected, 65 years of age or older, permanently and totally disabled, blinded, or suffering from dementia,including Alzheimer's Disease. The observations and support of The American Legion toward maintaining the veteran patient in a community or family setting to the greatest extent possible through the use of noninstitutional services are set forth in our comments on section 8 of S.2388. We are supportive of the current VA Hospital-Based Home Care program, and agree that a need exists for the expansion of this program. Thus, we support the provisions set forth in section 3. However, we would recommend that language be included to provide that the contract services are closely monitored to ensure that veterans are not treated haphazardly without adequate oversight by VA. In addition, implementation of these arrangements will expose the VA medical care system to possible attempts of mainstreaming by some private sector health care providers. Thus it would be extremely important that, VA serving as the primary source of health care, establish and maintain mutually beneficial relationships with the contract providers in the community.

Section 4 calls for the establishment of a program of community residential care for chronically mentally ill veterans under chapter 17 of title 38. The purposes of this provision are to establish the program as a legislative priority, and to assist VA in its efforts to develop a comprehensive network for the care of veterans with chronic mental illnesses.

Section 630 of title 38 currently provides that the Administrator may provide assistance by referring a veteran for placement, and aiding the veteran in obtaining placement in a community residential care facility in certain instances. This may be accomplished if the Veterans Administration is furnishing the veteran medical services on an outpatient basis, or furnishing hospital, domiciliary, or nursing home care; or has furnished the veteran such care within the preceding 12 months; and placement of the veteran in a community residential care facility is appropriate. It is important to note that under existing provision of section 630, the Veterans Administration is not responsible for the payment of the charges of a community residential care facility for any care or service provided to a veteran referred to the facility by VA under this section.

The provision under consideration would provide VA with the authority to contract for care to be furnished in halfway houses, therapeutic communities, psychiatric residential treatment centers and other community-based treatment facilities. This authority would extend to veterans who are being furnished

VA hospital, nursing home, domiciliary or outpatient care. The psychiatric residential treatment would be provided, at VA expense, if it is determined to be medically appropriate and in the best interests of the veteran.

The VA medical center is to provide unified case management services for each veteran involved in the program. In addition, VA would be authorized to provide in-kind assistance to a contract facility, under certain conditions. Not later than 1 year after enactment, the Administrator would be required to submit to the Committees on Veterans Affairs a detailed report on his evaluation and findings of the program.

Mr. Chairman, the program described in this section would be properly included among the treatment techniques and modalities to which we have referred and offered the support of The American Legion earlier in this statement, and during previous hearings of this Committee.

We do feel it important to stress the need for follow-up, as an integral part of the case management, particularly at a point in time when it is determined that the veteran is able to reside at home. There are already too many people residing in the streets, vulnerable to assault and other criminal acts, and dependent upon the charity of others, who have been released from State mental health facilities and other programs with little or no follow-up supervision provided to determine their ability to remain self-sufficient.

Section 5 provides the Chief Medical Director with the authority to waive the State licensure requirements of psychologists in the case of a psychologist who is to be used on a research or an academic post or where there is no direct responsibility for the care of patients; or in any case where the person is to serve in a country other than the United States and the person's licensure or registration is in the country in which the person is to serve.

The CMD currently has the authority to make such waivers in the cases of physicians, dentists, podiatrists and optometrists, and we have no objection to the inclusion of psychologists for the purposes set forth in 38 USC 4114(d).

Section 6 would amend section 5010 of title 38 by including domiciliary beds along with the hospital and nursing home beds that must be maintained at a level of not less than 90,000 in the VA medical care system so as to maintain a contingency capacity to assist the Department of Defense in treating casualties in time of war or national emergency.

We understand that the purpose of this section is to provide flexibility to the Department of Medicine and Surgery in its maintanence of beds in the 172 Medical Centers. However, we continue to be concerned about the fact that the number of acute care beds within the system has steadily eroded over the past several years. As we stated to this Committee in our testimony on the FY 1987 VA Budget proposal, in the past six years 4,900 acute care beds have been eliminated, not including the decrease of 2,700 beds proposed for FY 1987. The number of nursing home beds has slightly increased, but by no means to the extent the acute care beds have been eliminated.

As of December 31, 1985 there were 7,028 domiciliary beds in the VA system. If this section were enacted, that same number of hospital and/or nursing beds could be eliminated from the system, and we do not feel that it is wise to allow that to happen when aging veterans are increasingly experiencing catastrophic illnesses, and we continue to hear of veterans being turned away from VA medical centers. Therefore, The American Legion must oppose this section of S.2445.

Section 7 would direct the Administrator to prescribe criteria and procedures for determining the priority to be accorded to State Home construction projects when applications have been approved under 38 USC 5035.

This program appears to be operating efficiently under provision of current law, and we see no reason to support a change.

Section 8 would direct the Administrator to establish and maintain an Ionizing Radiation Registry. The Registry would include a list containing the name of each veteran who was exposed to ionizing radiation during nuclear weapons testing or the occupation of Hiroshima and Nagasaki, and who has requested hospital or nursing home care as a result of this exposure; or has filed a claim for compensation based on a disability which may be associated with radiation exposure. A veteran's name is also to be included if a spouse or child has filed a claim for dependency and indemnity compensation or pension on the basis of the veteran's exposure to ionizing radiation.

The Registry is also to include specific medical data relating to each veteran, and a statement describing any birth defects occurring in the natural children of the veteran. In addition, a radiation dose estimate for each veteran is to be included.

Not later than 1 year following date of enactment, the Administrator would be required to analyze the information collected in the Registry and submit to the Committees on Veterans Affairs and the VA Advisory Committee on Environmental Hazards a summary of the analysis. Not later than 90 days thereafter, the Advisory Committee is to review the analysis and transmit to the Committees such comments on the analysis it considers appropriate.

The American Legion is extremely supportive of this section. A significant number of veterans who were present during nuclear weapons tests during the period 1945-1962, have subsequently developed leukemia and other similar diseases which may well be linked to their exposure to radiation. There is a difference of opinion among the scientific community as to how much radiation is dangerous. The data that is collected in the Ionizing

Radiation Registry could be of help to researchers and policy makers in their efforts to resolve the questions that are unanswered with respect to the total effects of exposure to various levels of ionizing radiation, and could also be substantially helpful in eliminating many problems that we face in handling claims for benefits based upon radiation exposure during military service.

Mr. Chairman, the next measure under consideration is S.2174, that would require that non-federal providers of hospital care and services receiving direct payment of Medicare funds for services to Medicare beneficiaries provide similar services to VA beneficiaries under VA payment policies. The bill provides that if the provider does not comply, the Administrator may report such noncompliance to the Secretary of Health and Human Services. The Secretary then would be authorized to arrange for corrective action, or to terminate the provider's status as an eligible Medicare provider.

The American Legion would not object to the enactment of this bill.

The final legislative proposal to be considered is S.1536, the purpose of which is to provide that per diem subsidies paid by the VA for the care of veterans in State Homes shall not be used to offset payments that are made under the Medicaid program for the purpose of assisting eligible veterans. The bill calls for this purpose to be accomplished through amendment to section 641 of title 38 that would state that the per diem payments made to States pursuant to this section shall not be considered to be a third-party liability for any purpose under section 1902(a)(26) of title XIX of the Social Security Act; and shall for the purposes of determining under that title the reasonable costs of services provided by a State Home, not be deducted directly or indirectly from the operating costs or other costs of the State Home.

The American Legion will not oppose enactment of S.1536. We are mindful that the situation in the State of Maine, involving the Medicaid deduction from State funding allocations for the State Veterans Home, equivalent to the VA per diem allowance per veteran patient, has caused significant problems for the Home, in its efforts to provide high quality care to its veteran patients.

This problem is complicated by the fact that, according to our understanding of current law governing Medicaid, and the interpretation of that law by relevant legal authority, the State of Maine has the legal authority to do what it is doing in this instance. We of the American Legion are not sure the provisions of S.1536, placing responsibility for the disposition of Medicaid funds into title 38, United States Code, is either legal or workable. We would suggest the Committee might give thought to obtaining a legal opinion on this point before it votes to dispose of this legislation.

Mr. Chairman, that completes our statement.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

VETERANS' BENEFITS AND HEALTH CARE PROGRAMS

WASHINGTON, D.C. MAY 20, 1986

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for this opportunity to present the views of the Veterans of Foreign Wars of the United States with respect to various pieces of legislation affecting veterans' benefits and health care programs. The VFW wishes to thank the Chairman and the Members of this Committee for holding this hearing.

Mr. Chairman, S. 2168, introduced by Senator Thurmond for himself and Senator Heinz would amend title 38 to include the organic residuals of frostbite and arthritis resulting from trauma incurred while a prisoner of war to the list of disabilities presumed to have been incurred or aggravated by military service and, therefore, deemed to be service-connected for the purpose of VA compensation and health care. The VFW strongly supports this measure inasmuch as it would provide clearly warranted compensation to a highly deserving segment of the veteran population.

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The next measure under consideration, S. 2186, introduced by Senator Murkowski for himself and Senators Thurmond, Specter, Denton, Abdnor and Hawkins, would exempt any amounts available to provide certain benefits to veterans with service-connected disabilities from sequestration under the "Balanced Budget and Emergency Deficit Control Act of 1985." Exempted from such reductions would be patient benefits which are payable from the VA's special therapeutic and rehabilitation activities' fund to veterans who have a service-connected disability; benefits under Chapter 21 of title 38 relating to specially adapted housing for disabled veterans; benefits under 38 U.S.C. 907 relating to burial benefits for veterans who died as a result of service-connected disability; and benefits under Chapter 39 relating to automobile and adaptive equipment for certain disabled veterans and members of the Armed Forces. The VFW strongly supports these provisions. This measure would also exempt from sequestration assistance under Chapter 31 relating to training and rehabilitation for veterans with service-connected disabilities; however, only with respect to training and rehabilitation of veterans with service-connected disability rated at 50 percent or more. The VFW strongly believes that all funds which are to be utilized for the training and rehabilitation of veterans with service-connected disabilities should be exempted from reduction under the Gramm-Rudman-Hollings Deficit Reduction Act. Certainly there are varying degrees of need among disabled veterans; however, there is clearly no variance with respect to our obligation to them.

The next measure we will address is S. 2187, introduced by Senator DeConcini, which would exempt from sequestration certain benefits for veterans and dependents and survivors of certain veterans which are paid based on service-connected disability or death of veterans. This bill would provide protection from such reductions for benefits provided under 38 U.S.C. Chapter 21, relating to the specially adapted housing for veterans with service-connected disabilities; 38

U.S.C. 907, relating to burial and funeral benefits; Chapter 39 of title 38 relating to automobile and adaptive equipment for veterans with certain service-connected disabilities; and Chapter 31 of title 38 relating to training and rehabilitation for certain veterans with service-connected disabilities. It our is interpretation that the aforementioned provision would totally exempt from sequestration and reduction Chapter 31 funding rather than only providing protection for training and rehabilitation of veterans whose service-connected disability is rated at 50 percent or more. If this is the case, the VFW supports this divergence from the similar provision contained in S. 2186. The VFW also applauds the provision contained in S. 2187 which would exempt from reduction under Gramm-Rudman-Hollings Chapter 35 of title 38 U.S.C., relating to educational assistance for dependents of veterans with service-connected disabilities rated total and permanent and for the survivors of those who died as a result of service-connected disabilities. Additionally, we strongly favor the language contained in this bill which is to prevent exemption of any of those service-connected benefits from resulting in a disproportionate cut in other benefits paid from the same account.

The VFW supports the enactment into law of S. 2304, sponsored by Senator Cranston for himself and Senators Matsunaga, DeConcini, Mitchell and Rockefeller. This bill would amend title 38 U.S.C. to extend the period of time during which veterans' readjustment appointments may be made from September 30, 1986 to September 30, 1989.

One of the most extensive bills under consideration today is S. 2422, sponsored by Chairman Murkowski of this Committee for himself and Senators Cranston and Thurmond. Due to time constraints imposed and this bill's large range, we will present our overall position on this legislation rather than a point-by-point analysis and interpretation. With one very important exception, the VFW is generally supportive of this measure which is to amend title 38, United States Code, to increase by 3.4 percent the rates of disability compensation for disabled veterans and the rates of dependency and indemnity compensation for surviving spouses and children of veterans; to improve the Veterans' Administration home loan guaranty program; to authorize certain debt collections; to authorize the Administrator of Veterans' Affairs to require additional information from certain fiduciary agents of veterans; to revise the authority of the Administrator of Veterans' Affairs to construct, alter, acquire, operate and maintain parking facilities at Veterans' Administration medical facilities; and to authorize an administrative reorganization in the Veterans' Administration.

The VFW, as has been alluded to, is adamantly opposed to the language we reviewed in the draft version of this measure cited as Section 301 "Administrative Debt Collection by Offset of Benefits." It is our understanding that this subsection would allow the Administrator to collect by offset of compensation or pension payable to a veteran by the VA, the uncollected portion of the overpayment of retired or retainer pay made to a veteran for service in the Armed Forces and also for any indebtedness associated with the veteran's participation in a plan prescribed in Subchapter 1 or 2 of Chapter 73 of title 10. We are incredulous that this otherwise meritorious measure could contain language which would allow for the garnishment of service-connected disabled compensation. To deprive a veteran of any part of the compensation he has earned with the price of his blood in the defense of this nation is reprehensible enough; but when one also takes into consideration that this could establish the precedent for wholesale garnishment of VA compensation and pension, it is absolutely intolerable. In this regard, it is our opinion that Section 302 of the draft bill entitled "Disclosure of Financial Information by Federal Fiduciaries" constitutes an unwarranted invasion of a veteran's privacy and a threat to his financial well-being and could only serve to a veteran's detriment.

Also contained in this legislative proposal is language pertaining to parking facilities at the Veterans' Administration medical facilities. The VFW is supportive of this provision; however, we would wish to see language included that would provide free parking for the VAVS volunteers. As has already been stated, the VFW is generally supportive of S. 2422 with the exception of our adamant opposition to the language providing for the "Administrative Debt Collection by Offset of Benefits."

The next measure that we will address at this time is S. 2423, introduced by Senator DeConcini. Once again we reviewed a draft version of this bill, and view favorably this legislation to provide veterans additional protection from reductions under the "Balanced Budget and Emergency Deficit Control Act of 1985." It provides that certain Veterans' Administration benefits which are paid based on the service-connected disability or death of a veteran to be paid in accordance with laws administered by the Veterans' Administration. Further, it requires that certain Veterans' Administration insurance programs and revolving funds and Veterans' Administration home loan guarantees for refinancing loans be administered in accordance with VA law. As with S. 2187, the VFW also favorably notes the language contained in this measure which would prohibit this protection from resulting in larger reductions in the accounts to which the protected benefits belong.

At this juncture, we will now address legislation pertaining to veteran's health care. Once again, due to time constraints and the very brief period of time we were afforded to review these legislative proposals, we will not attempt to independently address each and every provision contained in these various bills.

We will begin with S. 2445, a bill sponsored by the Chairman of this Committee, Senator Murkowski, entitled "Veterans' Health Care Programs Improvement Act of 1986." This measure is represented as being a bill to amend title 38 U.S.C. to improve certain Veterans' Administration health-care programs.

Section 2 of this measure would clarify the VA's authority to provide respite-care services. Respite care, a relatively new concept in this country, provides the benefits of home care and that sometimes necessary care which can only be provided by a medical facility. While the VA has experimented with the feasibility of respite care, current law does not clearly indicate when it might be authorized. This proposal, if enacted, would effectively eliminate this discrepancy.

Section 3 would provide the Administrator the authority to furnish hospital based home care on a contractual basis. It is hereby intended to provide such care to a veteran who is unable to perform the necessary activities of daily living, but, considering the veteran's disability, does not require nursing-home care. The VFW is generally supportive of this provision and applauds the language contained therein which stipulates that it shall not be construed to limit or reduce the nursing-home care and adult-day home care programs provided by the Veterans' Administration. We both concur and insist that this provision not in any way encourage the limitation or reduction of the aforementioned VA health care programs for veterans.

Section 4, entitled "Treatment and Rehabilitation for Chronically Mentally Ill Veterans," would provide community based psychiatric residential treatment for chronically mentally ill veterans on a contractual basis. This proposal addresses the concept of "case management" for the coordination and facilitation of all services furnished to a veteran by the VA. Once again the VFW would support this provision.

Taken individually, the VFW favors the three aforementioned sections. Each of which would allow for the care of certain groups of veterans and their particular needs. However, it is our concern that the quality of care furnished to participating veterans through contract facilities be absolutely top notch and in keeping with VA standards. The VA must remain as the guarantor of veterans' health care and the primary source and conduit through which such care is provided. A fundamental concern is that these and other provisions contained in this measure do not address enhancing the VA's own in-house capability to provide veterans' health care.

Section 5 of S. 2445 would provide the authority to waive a licensure requirement for certain Veterans' Administration psychologists. This would add psychologists to the list of health care professionals, including physicians, who already enjoy this waiver authority for the purpose of completing internships and residencies. The VFW has no objection.

Similarly, the VFW has no fundamental objections to Section 7 of this measure which pertains to State Home Grants provided to assist the states to construct or acquire state-home facilities for furnishing domiciliary or nursing-home care to veterans.

With respect to the provision contained in this measure addressing the establishment of a Ionizing Radiation Registry, the VFW is very much in favor of implementing this recommendation. The VFW has long held that such a registry should be established. Further, we would like to see the information gathered through such a registry put to immediate use toward discerning and then contending with the health problems resulting from exposure of Ionizing Radiation.

It is now apparent that we have not yet addressed Section 6 of this measure entitled "Operating Bed Requirements"--this was not an oversight. The VFW is absolutely opposed to this misguided proposal to include domiciliary beds with the number of beds which the Administrator must operate and maintain for the care and treatment of veterans and as a contingency component to assist the Department of Defense in the event of war or national emergency. It is clearly not the intent of the law to lump domiciliary beds together with hospital and nursing-home beds.

Hospital and nursing-home beds are labor and medical intensive units exclusively suited to provide the highest level of medical care necessary when caring for the severely injured and disabled. In contradistinction, domiciliary care is merely a program offering shelter, subsistence and continuing rehabilitative medical care on an ambulatory self-care basis. It is readily apparent these domiciliary beds are absolutely unsuited for the provision of anything but the lowest level of medical care to those who are essentially already able to care for themselves. The VFW would point out that the VA is now operating 77,993 hospital beds and 11,102 nursing beds for a total of 89,095. This is over 900 beds less than the VA is currently mandated by law to operate. However, if the 7,028 VA domiciliary beds were suddenly forced into the tally, the VA would be operating in excess of 6,000 beds above the mandated number. The way would be paved for a drastic and disastrous reduction in the number of operational VA medical care beds. Who is it to say, instead of the 37,000 veterans a month who are now being denied VA health care, we could have ten times that number being deprived of needed medical attention and the VA's ability to back up DOD would be similarly undermined. The law excluded domiciliary beds from the mandated number of VA operational health care beds for a very good reason; it is our very strong-held conviction that they should remain excluded.

We will now address S. 2174 which Chairman Murkowski introduced by request which is to amend title 38 U.S.C. to require that non-federal providers of hospital care and services receiving direct payment of Medicare funds for Medicare beneficiaries provide similar services to Veterans' Administration's beneficiaries under similar Veterans' Administration payment policies. The VFW would support the enactment into law of this measure inasmuch as it provides for the nondiscriminatory treatment of veterans in need of health care by the private sector.

The next bill under consideration is S. 2388, sponsored by Senator Cranston, Ranking Minority Member of this Committee, which is to improve various aspects of Veterans' Administration's health-care programs.

The VFW has no objection to Section 2 of this measure which pertains to the enforcement of state and local traffic laws by VA police officers.

The VFW strongly supports Section 3 entitled "Services to Overcome Service-Connected Disability Affecting Procreation." The VFW feels that such a program is long overdue, and we welcome its implementation by the VA both through its own facilities and on a contractual basis with the private sector where appropriate.

The VFW supports Section 4 of S. 2388 which will allow for the continuation of certain counseling services for a deceased veteran's family members. We do question, however, the language contained in this section which would provide that the dependents or survivors of a veteran be eligible for the same medical services as a veteran. We do not believe that it would be appropriate to afford nonveterans the same level and degree of care as veterans under title 38.

The VFW has no objection to Section 5 of this measure entitled "Extension of Eligibility for Readjustment Counseling and Related Mental Health Services." We believe that such counseling is, indeed, necessary for certain veterans of the Post-Vietnam Era who have been subjected to hostilities. We would only ask that language be included to require the Department of Defense to share the cost with the Veterans' Administration in those cases where such counseling is provided to a member of the Armed Forces.

The VFW strongly supports the enactment into law of Section 7 entitled "Respite Care Pilot Program." As we have stated earlier, the VFW believes that such care would greatly benefit the veteran patient and those who labor on his behalf.

On the surface, the VFW has no objection to Section 8 entitled "Pilot Program of Non-Instutional Alternatives to Institutional Care." We favor the provision of health care to veterans outside of the institutional setting where possible and appropriate. We note that a provision of Public Law 98-528 requires a report to be issued on this very matter. We would very much like to have access to and then review this report before delivering any further comments on this issue.

The VFW has no objection to Section 9 which provides that the Administrator should prescribe all rules and regulations which are necessary and appropriate in promoting good conduct on the part of persons who are receiving care or services in VA facilities.

The VFW supports Section 10 which would extend to September 30, 1989 the Administrator's authority to enter into contracts with the Veterans' Memorial Medical Center of the Philippines to provide health care to veterans.

The VFW supports Section 11 which would amend 38 U.S.C. 1520 to make permanent the Administrator's authority to enter into contract with nonprofit public or private agencies or organizations to provide independent living services for service-connected disabled veterans.

The VFW strongly supports Section 12, the concluding provision of S. 2388, which extends the authorization for appropriations for grants to state veterans' homes to 1991.

The final bill to be addressed at this hearing is S. 1536, introduced by Senator Mitchell for himself and Senator Cohen. This bill would provide that per diem subsidies paid by the Veterans' Administration for the care of veterans in state homes shall not be used to offset payments that are made under the Medicaid program for the purpose of assisting eligible veterans. It is clear to us that VA per diem should not be considered a resource of an individual veteran because the VA makes the payment to the home, not the individual. It simply does not make any sense for the Congress to authorize the VA to make payments to state veterans' homes on behalf of veterans only for those funds to be used by state agencies to replace state and federal Medicaid dollars with no benefit to the veteran. It is our belief that the enactment into law of S. 1536 will be an important step toward insuring that state veterans' nursing homes are able to provide the level of care to veterans that the Congress intended when it wrote the relevant laws.

Mr. Chairman, germane resolutions adopted by the voting delegates to our most recent National Convention are attached to my testimony.

Thank you and I will be happy to respond to any questions you may have.

Resolution No. 673

## DO NOT BREAK FAITH WITH VETERANS - MAINTAIN BENEFITS

WHEREAS, war veterans have been provided special benefits and privileges since 1636 when the colonies enacted legislation to care for those that served in defense of the colonies; and

WHEREAS, each succeeding year the Congress of the United States has enacted legislation to provide special benefits and privileges for war veterans in need; and

WHEREAS, proposals by the Administration, if enacted by Congress, will break a tradition of providing benefits, including medical care, to individuals that served the Nation in time of war; and

WHEREAS, the majority of men and women that served in time of national emergency have not received compensation, pension, medical care or other benefits provided by Congress; and

WHEREAS, war veterans served their country in time of war and continue to serve as dedicated, law-abiding citizens paying their share of taxes without VA benefits; and

WHEREAS, the current proposals by the Administration to consolidate VA Regional Office, establish a user's fee for G.I. loans, establish financial need for medical care, and taxing VA compensation and pension are most detrimental to those veterans in need; and

WHEREAS, World War II veterans reaching age 65 will be unable to continue to provide for themselves without VA benefits; now, therefore

BE IT RESOLVED, by the 86th National Convention of the Veterans of Foreign Wars of the United States, that we hereby go on record petitioning the Congress of the United States to not break faith with those veterans that served the Nation in time of war by reducing or curtailing current benefits provided by the Veterans Administration.

Adopted by the 86th National Convention of the Veterans of Foreign Wars of the United States held in Dallas, Texas, August 16-23, 1985.

Resolution No. 697

## USE OF VA PER DIEM IN STATE VETERANS HOME

WHEREAS, State Veterans Homes are certified as providers of service in the Federal-State Medicaid Program; and

WHEREAS, in order to be eligible for the Medicaid Program all income available to a veteran over and above approximately $1,500.00 in assets which the veteran is allowed to retain and $35.00 monthly personal needs money, is applied against the cost of care; and

WHEREAS, a veterans' pension, compensation, plus aid and attendance benefits are all considered income and applied against the cost of care; and

WHEREAS, the average veteran on Medicaid, because of this assessment of veterans benefits, pays a larger amount toward his care in a nursing home than the average nonveteran; and

WHEREAS, the Veterans Administration stipend of $17.05 per day is payable to State Veterans Homes providing nursing care in order to improve the quality of that care; and

WHEREAS, the quality of care will not be improved if Medicaid programs apply the stipend to offset either, or Federal-State Medicaid payments to the Home; and

WHEREAS, the Veterans of Foreign Wars of the United States does not believe it is intended to use Veterans Administration appropriations to supplant Federal and/or State Medicaid funds; now, therefore

BE IT RESOLVED, by the 86th National Convention of the Veterans of Foreign Wars of the United States, that we support the introduction and passage of legislation to amend 38 USC to provide that the per diem paid by the Veterans Administration for the care of veterans in State Homes shall not be used to offset payments made under Medicaid for the purpose of assisting eligible veterans.

Adopted by the 86th National Convention of the Veterans of Foreign Wars of the United States held in Dallas, Texas, August 16-23, 1985

Resolution No. 697

Resolution No. 717

## VETERANS' HEALTH CARE

WHEREAS, Congress on July 21, 1930, established the Veterans Administration health care system and progressively increased their responsibilities to administer veterans' benefits; and

WHEREAS, attempts are now being made to drastically alter and reduce veterans health care (long and short term) benefits through budgetary constraints such as "mainstreaming" veterans away from veterans facilities into the private sector; barring veterans with nonservice-connected disabilities from eligibility or eliminating construction and maintenance of hospitals, domiciliaries, nursing care homes/units; reimbursing the VA from third parties; reducing VA staff and regionalizing; and

WHEREAS, the VA cuts in the health care system will not only affect the veterans, but also their dependents and all political, economic and social lines; and

WHEREAS, with the demographic increase of the aging veteran population plus younger veterans, the quality of comprehensive health care in a VA facility is unparalleled, and is no more expensive than other federal health care programs and less expensive than private systems to care for all needy veterans (long and short term); now, therefore

BE IT RESOLVED, by the 86th National Convention of the Veterans of Foreign Wars of the United States, that we support maintaining federal funding for the VA health care system benefits for ALL veterans, plus increasing VA health care facilities (hospitals, domiciliaries and nursing care homes/units) to provide long and short term care due to the increasing needs of the aging and younger veterans.

Adopted by the 86th National Convention of the Veterans of Foreign Wars of the United States held in Dallas, Texas, August 16-23, 1985.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SENATE COMMITTEE ON VETERANS AFFAIRS
May 20, 1986

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans and it Ladies' Auxiliary, I deeply appreciate this opportunity to appear here today to present our views on legislation relating to the Veterans Administration's health care system.

Mr. Chairman, our testimony has been requested relating to the following legislation currently pending before the Committee: S. 2445, the "Veterans' Health Care Programs Improvements Act of 1986;" S. 2388, the "Veterans Administration Health Care Programs Extension and Improvement Act of 1986;" S. 2174; and S. 1536.

We will discuss the individual provisions of each bill separately, save those provisions of S. 2445 (Sections 2, 3, and 7) and S. 2388 (Sections 7, 8, and 12) which concern subject matter of a similar nature.

## S. 2445

Section 4 of the bill proposes to add a new section (Section 620B) to Chapter 17, Title 38, United States Code, permitting the Administrator to enter into contracts for the provision of care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community based treatment facilities for eligible veterans suffering from chronic mental illness disabilities.

Mr. Chairman, while we are in general agreement with the perceived intent of this measure -- to diminish the need for inpatient care and to allow disabled veterans to achieve a degree of independence in living and functioning in the community -- we have one major concern that we feel must be addressed.

This measure appears to expand the VA's existing Community Residential Care Program. Additionally, current law, Section 630(b)(3), Title 38, United States Code, specifically precludes the VA from assuming any financial responsibility for community residential care of veterans.

We are, therefore, concerned that similarly situated veterans requiring community residential care but without a chronic mental illness will be dealt with in an inequitable fashion.

The DAV is not able to support this provision absent a consensus being reached wherein the VA will be required to pay the charges of community residential care for all veterans or a continuation of the current mandate to incur no costs for such services.

Section 5 of the bill proposes to amend Section 4114(d), Title 38, United States Code, permitting the VA to waive the licensure requirement for the purpose of employment in the Department of Medicine and Surgery of psychologists, when such individuals will be utilized in a research or academic assignment or where they will have no direct responsibility for the care of veterans.

Mr. Chairman, the DAV has no official position nor objection to the enactment of this provision.

Section 6 of the measure would, through appropriate amendment to Section 5010(a)(1), alter the methodology utilized by the VA in calculating the minimum number of beds (90,000) that are mandated to be operated and maintained for the care and treatment of disabled veterans.

Mr. Chairman, the DAV opposes this provision.

It is evident that the VA is currently circumventing the law by operating approximately 1,800 fewer beds than that which is required by law and it is projected that in Fiscal Year 1987 bed levels will drop 4,000 below statutory requirements.

Available information reveals the VA has, is and plans to continue, the systematic closure of significant numbers of acute care beds without a simultaneous addition -- through conversion or construction -- of badly needed nursing home care beds.

These actions create the obvious impression that very real attempts are being made to "shrink" the size and scope of the VA's Department of Medicine and Surgery. This, in turn, will only exacerbate the current trend of denying access to medical care to veterans requiring such care. (Current estimates are that approximately 35,000 veterans per month are being denied needed VA health care services.)

As you are well aware, Mr. Chairman, the VA, and indeed the entire nation, will soon be faced with the challenge of providing medical care to a rapidly aging population.

According to VA statistics, there were three million veterans age 65 and older in 1980, constituting 10.5% of the total veteran population. By 1990, this figure is expected to rise to 7.2 million, representing 26.6% of the total and by the year 2000, the number will reach nine million, translating to 37% of the veteran population.

It is obvious, in our view, that this large influx of aging veterans will place an increased demand on the VA to provide a full array of acute and skilled long term care services. The continued shutdown of hospital beds clearly places the VA's ability to provide required medical care in jeopardy.

Additionally, the VA's mandate to serve as the primary medical backup to the Department of Defense in the event of war or national emergency is in danger if sufficient numbers of acute care beds are not operated and maintained by the agency.

Mr. Chairman, one last point we wish to make regarding this measure relates to the actual extent and scope that VA Domiciliaries play in the provision of medical services to veterans.

Although it may be argued that domiciliaries provide medical care to eligible veterans, it is clear that the level of any medical care provided is far less intensive than that provided in the traditional hospital or nursing home care environment.

Generally stated, the focus of care provided in a domiciliary is rehabilitative or therapeutic in nature and is designed to prepare the veteran to function at the highest possible level of independence in the community.

Mr. Chairman, our opposition to this provision is predicated upon our feeling that it simply serves as a ready mechanism to bring the VA into compliance with current law. By doing so, the real problem -- the operation and maintenance of a sufficient number of hospital and nursing home care beds to provide needed medical services to disabled veterans -- is not being addressed.

Mr. Chairman, we have no objection to the enactment of

Section 8 of this measure which would mandate the Administrator to establish and maintain a special record to be known as the "Ionizing Radiation Registry."

As we understand it, certain specific information would be included in the case of each veteran who has requested hospital or nursing home care or has filed a claim for disability benefits with the VA. The name of a deceased veteran, if survived by a spouse, child or parent who has filed a claim for Dependency and Indemnity Compensation or death pension would also be included.

The registry would not be required to include the names of veterans, as identified in the bill, who filed claims or died prior to enactment of this measure.

If favorably reported, we would suggest language be included to encourage the Veterans Administration to undertake serious efforts to attempt to identify -- to the extent possible -- all veterans who had previously filed claims relating to exposure to ionizing radiation.

## S. 2388

Section 3 of the bill proposes, through appropriate amendment to Clause (A) of Section 601(6), Title 38, United States Code, to include in the definition of medical services "...services to achieve pregnancy in a veteran or a veteran's spouse where such services are necessary to overcome a service-connected disability impairing the veteran's procreative ability...."

While the DAV has no official position to the perceived intent of this measure, we feel explanatory report language is required to express the limitations of this bill.

Our interpretation is that services would be provided to "...achieve pregnancy..." (emphasis added). Therefore, we do not envision the VA to be required or provide obstetric services, prenatal or postnatal care in conjunction with any successfully achieved pregnancy. We would also raise the issue of the Agency's potential liability relating to possible complications and/or permanent disability to the mother or possible birth defects affecting the child.

Section 4 of this measure would amend Clause (B) of Section 601(6) permitting the VA to provide certain counseling services to family members, who were receiving such services at the time of the veteran's death, for a period not to exceed six months following the veteran's death.

We believe such "bereavement" counseling may be described as an integral portion of the total care to be provided to the terminally ill veteran.

This is so, due to the nature of the treatment employed in preparing the veteran and family for death from a physical, social, spiritual and emotional standpoint.

Mr. Chairman, we have no objection to the enactment of this measure so long as funding for that portion of the program expended for nonservice-connected veterans does not adversely impact upon the programs and services that would otherwise be provided to service-connected disabled veterans.

Mr. Chairman, the DAV supports Section 5 of the bill which proposes to amend Subsection (b) of Section 610, Title 38, United States Code, to clarify and simplify the eligibility criteria for receiving domiciliary care.

Section 6 of the measure would amend Section 612A, Title 38, United States Code, regarding eligibility for readjustment counseling and related mental health services to certain veterans and individuals who:

> are still on active duty and served on active duty during the Vietnam Era; or
>
> are veterans or are serving on active duty and served on active duty after May 7, 1975 in an area during a period in which hostilities occurred in such area.

Mr. Chairman, we have no objection to expanding eligibility for readjustment counseling to those veterans who served on active duty after May 7, 1975 and were subjected to the dangers from hostile or armed conflict comparable to the dangers experienced by military personnel in battle with the enemy during a period of war.

However, we do not favor extending these types of counseling services to active duty personnel. If a need exists for active duty personnel to receive readjustment counseling services, it is certainly feasible and within the realm and responsibility of the Department of Defense to provide these types of services by utilizing their existing resources or by entering into a sharing agreement with the Veterans Administration.

Section 9 of the bill would amend Section 621, Title 38, United States Code, by, as we understand it, substantially revising the Administrator's authority to issue rules and regulations relating to the provision of VA medical care.

The VA's Office of General Counsel drafted a white paper in conjunction with last year's Congressional actions regarding the Omnibus Budget Reconciliation Act of 1985 wherein Section 621 was the subject of some discussion.

Mr. Chairman, it was concluded by General Counsel that

Section 621, as currently constructed and codified, grants the Administrator broad authority and significant discretion to determine what medical care should be provided or not provided to otherwise eligible veterans. In fact, it was readily acknowledged that Section 621 would allow the Administrator to deny medical care to veterans who otherwise required such care.

This provision would, in our view, mandate the Administrator to prescribe all rules and regulations governing the furnishing of VA hospital, nursing home and domiciliary care, as well as medical services, under laws administrated by the Veterans Administration and which are consistent with such laws.

As we feel this measure would require the Administrator to comply with the intent of Congress, thereby limiting his discretionary authority, we have no objection to enactment of this provision.

The DAV has no official position with respect to Section 10 of the bill which would extend, for three years, through Fiscal Year 1989 the VA's authority relating to the furnishing of health care in the Philippines.

Section 11 of the bill would make permanent the VA's authority to provide a program of independent living services and assistance for severely disabled service-connected veterans when it is determined that achievement of a vocational goal is not reasonably feasible.

Mr. Chairman, although only a relatively small number of veterans participated in the pilot program, we are of the opinion that their lives were substantially enhanced and that these severely disabled veterans regained a positive sense of self worth and allowed them to function in a more fully independent fashion.

We, therefore, support enactment of this provision.

Section 7 of S. 2445 proposes to make certain changes in the State Extended Care Facilities Construction Grant Program to include: defining the term "construction;" the purpose of the program; and requiring the Administrator to prescribe criteria and procedures to assign a priority to each application received from a state seeking such a grant: Section 12 of S. 2388 proposes to extend the authorization of appropriations for this program through Fiscal Year 1991.

As you know, Mr. Chairman, this program provides grants to assist states to acquire or construct state home facilities for furnishing domiciliary or nursing home care to veterans and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home or hospital care to veterans in state homes.

Without question, the domiciliary, nursing home and hospital care provided to this nation's veterans by state veterans homes has been invaluable in terms of offsetting the severe losses suffered by the VA's health care system.

Recognizing the significant and important role of state veterans homes -- in terms of care provided to the rapidly aging veteran population and the cost effective use of federal taxpayer dollars that supplement this program -- we believe it is indeed wise to continue funding this program that ultimately produces savings to the government in terms of both construction and health care costs.

While we favor extension of the program, we are nevertheless concerned with the proposal to require the VA to assign a priority to each application received from a state seeking a grant for construction, expansion, remodeling or altering existing buildings of state home facilities.

Additionally, we find no compelling circumstances that would prompt us to support major changes in an established and apparently effective program that has otherwise funded projects in what appears to be an equitable and appropriate fashion.

Mr. Chairman, the DAV supports extension of this program through Fiscal Year 1991 as it would satisfy Resolution No. 128 as adopted at our most recent National Convention.

Section 2 of S. 2445 and Section 7 of S. 2388 would provide the Administrator with the authority to furnish respite care services to eligible veterans.

As you know, Mr. Chairman, respite care is a relatively new concept in the array of long term care services. Generally stated, respite care is capable of providing a wide range of services that offer a degree of relief to the spouse or primary care giver who has assumed the responsibilities of caring for a veteran diagnosed as suffering from a chronic illness.

Disabled veterans may be provided with short term, intermediate, or temporary stays at VA facilities in order to provide the primary care giver with a "break" from providing constant care and monitoring of the veteran.

It is our opinion that this type of alternative approach will not only provide incentives for principal care givers to continue to provide necessary care in the home, but will also contribute to a reduced incidence of hospital and nursing home admissions for otherwise necessary long term care.

While we favor the intent espoused in both measures, we are particularly pleased to note the provisions of S. 2388 which will provide these services to a veteran who has a service-connected disability, compensable in degree, and we suggest that this language be retained should this measure be favorably reported.

Section 3 of S. 2445 would permit the Administrator to furnish certain specifically defined veterans with certain non-medical services such as personal care, homemaker, nutrition and transportation services as an alternative to receiving hospital or nursing home care: Section 8 of S. 2388 would mandate the Administrator, to conduct a pilot program to provide health related services in a non-institutional setting that would obviate the need for hospital or nursing home care.

Initially, Mr. Chairman, I want to state that the DAV supports the intent embodied in both bills. We have long advocated that providing necessary medical and certain non-medical services to veterans to avoid institutionalization is a desirable approach, both from a cost effectiveness standpoint and, more importantly, for the overall well-being of the veteran.

Mr. Chairman, to enable these provisions to succeed in their intent, we feel it desirable to define, in part, what is envisioned by the term "health related services." This term should, in our view, include, but not be limited to:

Domestic
Bathing
Feeding
Grooming
Changing patient's clothes
Transporting patients
Oral hygiene
Dressing
Diet Management

Homemaker
Housecleaning
Food Preparation
Marketing
Washing clothes

Custodial
Assistance with daily needs
Turning patients
Catheter irrigation
Massage
Ambulation
Sitter services
Changing colostomy bags
Changing simple dressings
Changing external catheters
Medicine Administration
Assistance with prosthetic devices
Position adjustment/transfers

Mr. Chairman, because we believe that flexibility in providing these types of non-medical support services is essential to obviate the need for institutionalization, we suggest, if this measure is favorably reported, that such services be defined as cited above.

We support, as proposed in S. 2388, the involvement (in the pilot program) of Geriatric Evaluation Units (GEUs) at VA health care facilities. The effectiveness of GEUs in the treatment of geriatric patients has, in our opinion, been proven to be of immeasurable value in improving the quality of care, as well as decreasing the rate of re-hospitalization of veterans.

Additionally, Mr. Chairman, we are pleased to note that both measures stipulate that the Administrator shall give priority for participation in the program to veterans with service-connected disabilities, as well as other veterans who, by virtue of their disabilities, would be most in need of such services.

The DAV supports the intent of both these measures as they would satisfy Resolution No. 386 as adopted at our most recent National Convention.

## S. 2174

Introduced by yourself, Mr. Chairman, this measure proposes to add a new section (Section 625) to Chapter 17, Title 38, United States Code, to require that any non-Federal provider of hospital services to any Medicare beneficiary must also accept Veterans Administration beneficiaries on a similar basis and must accept payments made by the VA in accordance with VA regulations as payment in full.

Mr. Chairman, the DAV opposes enactment of S. 2174 for two major, specific reasons.

Initially, it is our view that enactment of this measure would place the provision of health care services to disabled veterans on an equal plateau as non-veteran Medicare beneficiaries.

It has been the long-standing and often stated opinion of the DAV that the sacrifices made by disabled veterans -- especially service-connected disabled veterans -- in service and defense of this nation warrant a degree of special recognition and consideration.

To place disabled veterans' health care needs on an equal basis as non-veterans is certainly diminishing this nation's obligation to veterans and is, in our opinion, demeaning to disabled veterans.

Additionally, and as you are well aware, Mr. Chairman, the Medicare program has adopted a payment system based on reimbursement of pre-determined dollar amounts for treatment of conditions falling within Diagnosis Related Groups (DRG).

While it is acknowledged that payments, based on DRGs, have produced savings in the Medicare program, it is widely stated that DRGs simultaneously result in an inferior quality of care being provided.

A number of studies have indicated that seriously ill Medicare patients are inappropriately and prematurely discharged from hospitals under the DRG reimbursement method. This is due, in large part, to hospitals exerting pressure on treating physicians to reduce length of stays and diminish certain procedures or tests that would otherwise be found desirable to be performed.

An additional problem arises in that DRGs do not adequately reflect or take into account the severity of illness. The transfer of certain patients from private to public hospitals for purely financial reasons -- a practice known as "dumping" -- has increased dramatically, resulting in unnecessary medical complications and, in some cases, death.

It is interesting -- and disheartening -- to note the results of a survey conducted by the American Medical Association which revealed nearly two-thirds of the participating physicians said that with the DRG system, the quality of care has declined or that it will deteriorate over time.

Disabled veterans need not be unnecessarily subjected to what has been referred to -- by many health care professionals -- as an inferior quality of care resulting from the DRG reimbursement methodology.

For these reasons, we again state our strong opposition to S. 2174.

## S.1536

S. 1536 proposes, via appropriate amendment to Section 641, Title 38 United States Code, to provide per diem subsidies paid by the VA for the care of veterans in State homes shall not be used to offsetpayments that are made under the Medicaid program for the purpose of assisting eligible veterans.

As we understand it, Mr. Chairman, VA per diem rates are considered by the Department of Health and Human Services as "third party" liability for the purpose of Medicaid.

As a result, Medicaid payments, made to the State homes for Medicaid eligible veterans - to our knowledge only four such homes exist - are reduced (or offset) by an amount equal to VA per diem payments made on behalf of the eligible veteran.

The intent of this bill, as we understand it, is relatively simple in that it would stipulate that payments made to State homes, by the VA, shall not be considered to be a third party liability - and thus not subject to offset - under Medicaid.

In our view, the intent of legislation authorizing per diem rates to be made to State homes was to assist the States in furnishing medical or nursing home care to veterans otherwise eligible to receive such care in VA operated facilities.

It makes little or no sense for the VA to make payments to State veterans homes on behalf of veterans only to have those funds used by the States to replace State and Federal Medicaid dollars. It does not seem as though the veteran is deriving any benefit from this procedure.

Mr. Chairman, the DAV supports this measure as it would satisfy Resolution No. 185 as adopted at our most recent National Convention.

Mr. Chairman, this concludes my testimony and I again want to thank you for allowing us to appear before the Committee.

STATEMENT OF
JOHN F. HEILMAN
NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
OF THE
UNITED STATES SENATE
May 20, 1986

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the over one million members of the Disabled American Veterans and its Ladies' Auxiliary, may I say that we deeply appreciate being given this opportunity to present our views on legislation relating to the service-connected disability and death compensation programs of the Veterans Administration.

## S. 2422

Mr. Chairman, the provisions of S. 2422, authored by yourself and Senator Cranston, would authorize (subject to actual Consumer Price Index movement) a 3.4% across-the-board increase in basic disability compensation and DIC (service-connected death) benefit rates. This same percentage rate of increase would also be extended to the dependency allowances and, with one exception, to the special statutory awards and ratings that apply to the compensation and DIC programs, as well as to the VA's annual clothing allowance, payable to certain service-connected veterans whose prosthetic or orthopedic devices cause unusual damage to clothing.

The proposed increases carry an effective date of December 1, 1986.

To put it in more meaningful terms, Mr. Chairman, the benefit increases would range from a modest $24 per year ($2.00 monthly) for a veteran with a 10% service-connected disability to $540 more per year ($45 monthly) for a veteran who is determined to be 100% totally and permanently disabled due to a service-connected disability.

Mr. Chairman, in any consideration of an increase in VA disability and death compensation payments, it is important to recall the principle upon which these programs were established:

> Disability compensation paid to veterans attempts to represent, to the most practical degree possible, the average impairment in earning capacity caused by service-connected disability. DIC benefits, on the other hand, are intended to provide a measure of financial security to surviving spouses and children of veterans whose deaths are attributable to a service-connected disability.

Over the years, this Committee has been most diligent in its effort to assure that the purchasing power of these benefits keeps pace with our society's rising cost of goods and services. The most recent adjustment of these rates authorized by Public Law 99-238 represented the 12th consecutive year that your Committee has taken action on this most important issue.

I do wish to make special note of the fact that in its provisions, S. 2422 does not propose to increase the "K" award as set forth in Section 314(k), Title 38, USC. This is a special monthly benefit -- presently $62 -- paid in addition to the basic rates of compensation of certain veterans who have incurred a service-connected loss or loss of use of a single extremity or certain other body organs and functions.

This particular award has not always been included in prior compensation bills and was last increased to its present amount by Public Law 96-128, approved in November, 1979. We therefore ask the Committee to include the "K" award in any compensation bill that it may recommend to the floor of the Senate.

Mr. Chairman, with the concern noted above, the DAV does support favorable consideration of the disability compensation/DIC adjustments proposed in Title I of the pending bill.

Having stated that, we also state, as we have done in recent years, our willingness to pose no objection should the Congress decide, for the economic well-being of our nation, that the cost of living adjustments (COLAs) in all federal programs should be foregone or subject to a delay in Fiscal Year 1987. The possibility of the Congress reaching such a consensus as a means to combat our rising national deficit would seem to be encouraged by Consumer Price Index (CPI) movement that has occurred thus far in 1986 -- +.03% in January and -.04% in both February and March.

However, in view of the fact that (in this election year) such a consensus on the part of the Congress may not materialize, we urge the Committee to move forward on these Title I provisions, favorably recommending them to the Senate.

Title II of the measure proposes, through appropriate amendment of Section 1816(c), Title 38, USC, to require that the VA Administrator, upon the default of a home loan guaranteed by the Veterans Administration, may not acquire (take title of) the property in question unless the Administrator has first determined that the VA is likely to be able, within one year after the date of the liquidation sale of the property, to sell the property for a price which would make it economically advantageous (to the United States) for the Administrator to acquire and sell the property.

Mr. Chairman, we are aware of the concern on the part of the Congress regarding the VA's inventory of acquired properties and the inability, in some cases, of the VA to dispose of such properties without sustaining a loss to the United States. We are also aware that in recent months, this "problem" has been particularly manifested in the Houston, Texas area.

Mr. Chairman, the DAV has no official position on this proposal, however, we do ask the Committee to fully consider if the above cited "solution" to the problem is fully justified based upon the national experience of VA home loan activity.

Undoubtedly, the Houston area, currently in an economic slump due to falling energy prices, has had and in the short run may continue to have a high rate of home foreclosures. We ask if this is reflected in other parts of the nation, as well?

Also, it is our understanding that the Director of the VARO in Houston attributed part of his "problem" to inflated (fee basis) appraisals that his Regional Office received on foreclosed properties -- VA would acquire a property which it later learned could not be quickly turned over in the marketplace. According to our information, the Director of the Houston VARO now indicates that steps have been taken to assure that the Agency receives accurate appraisals and that, in fact, his Regional Office is decreasing the number of properties acquired.

In view of the above, we suggest the Committee insure that it not move forward with the proposed change of law if, in fact, it is an action that is not necessary.

Title III of S. 2422 contains four proposals, specifically:

1. to amend Section 3101, Title 38, USC, to permit administrative offset against veterans' disability compensation/pension benefits in order to collect overpayments of military retirement/retainer pay and delinquent Survivors Benefit Plan (SBP) and Retired Serviceman's Family Protection Plan (RSFPP) payments;

2. to amend Section 3202(d), Title 38, USC, to require greater accountability (to the VA) on the part of fiduciaries;

3. to authorize the VA Administrator to construct, alter or acquire parking facilities at VA medical facilities and to charge fees for the use of such facilities; and

4. to authorize a waiver of reorganization requirements under Section 210(b)(2), Title 38, USC, for certain Veterans Administration activities.

With respect to the first proposal, Mr. Chairman, while we are sympathetic to the goal of recovery of overpayments and indebtednesses to the government, the DAV does not support the proposed modification of Section 3101, Title 38, USC.

The above cited overpayments of course occur in those cases where a service-connected veteran, who is also a military retiree, waives, either wholly or partially, military retirement/retainer pay in order to receive VA disability compensation benefits. Such waivers are initiated due to the current Section 3104, Title 38, USC, prohibition which bars dual receipt of these benefits, and in order for disabled veterans to receive VA disability compensation which may be in greater monetary amounts than retirement/retainer pay and which, in all cases, is tax exempt.

Mr. Chairman, the current safeguards of Section 3101 were initiated for the express purpose of protecting veterans' benefits from the claims of creditors. The VA has consistently interpreted this provision of law as excluding, except on a voluntary basis, the offset of veterans' benefits to satisfy indebtednesses, both public and private, including those arising out of programs administered by other federal agencies.

Moreover, all federal departments and agencies (including the VA and the Uniformed Services) can take steps to recover overpayments/indebtednesses which include such courses of action as recovery from past and future benefit entitlement; recovery through judicial proceedings; recovery through Internal Revenue Service refund offsets; and even the use of private debt collection agencies.

As stated above, we can sympathize with the goal of debt collection and we do recognize the special relationship between the VA and the Uniformed Services. However, we see no overriding arguments in the instant case that would warrant violation of the long-standing Section 3101 protection of current law.

In our view, this proposal could well be the first step toward the VA becoming a "collection agency" for all governmental overpayments and indebtednesses -- if we authorize offset of Uniformed Services overpayments today, why not Social Security Administration overpayments tomorrow? And, ultimately, why not indebtednesses to Sears and Roebuck and Montgomery Ward?

No, Mr. Chairman, let the Department of Defense recover its own overpayments...goodness knows, their resources are far greater than the VA's.

With respect to the second proposal requiring greater accountability on the part of VA fiduciaries, we recognize and agree that such a change is proposed to enable the VA to improve its oversight of fiduciary actions and to protect VA beneficiaries from possible misappropriation of their entitlements. The DAV therefore supports this proposal.

The third proposal, Mr. Chairman, through appropriate amendment of Section 5009, Title 38, USC, proposes to authorize the establishment of a revolving fund for the construction, alteration and acquisition of parking facilities at VA medical facilities and to confirm existing authority of the VA Administrator to establish and charge reasonable parking fees at such facilities.

We note the authorization for collection of parking fees shall only apply to medical facilities where a parking facility is constructed, acquired or altered at a cost in excess of $500,000 after September 30, 1986 and that fees shall not be collected for any vehicle that is used to transport a veteran to or from any medical facility for the purpose of examination or treatment. We further note that parking fees collected by the Administrator will be used for the operation and maintenance of such parking facilities.

Mr. Chairman, with one exception, the DAV has no objection to favorable consideration of this proposal which, we recognize, represents an attempt to address, in the most economic and equitable fashion possible, the parking "problem" found at many VA medical facilities.

The exception cited above centers on the fact that the existing Section 5009 authority for the Administrator to establish and collect parking fees, in addition to exempting vehicles used for the transportation of veterans seeking treatment, also excludes vehicles used for the purpose of visiting veteran patients.

We respectfully request that the pending proposal be modified to also exempt from parking fees vehicles used for the purpose of visiting veteran patients.

As stated above, the fourth proposal in Title III of S. 2422 proposes a Section 210(b)(2) waiver to allow the reorganization of certain VA activities, specifically:

1. the transfer of the Audio-Visual Service out of the Office of Administration to the Associate Deputy Administrator for Public and Consumer Affairs; and

2. the transfer of the Presidential Memorial Certificates function out of the Office of Administration to the Department of Veterans Benefits.

Mr. Chairman, we understand the above cited functions involve a total of 39 personnel and that such transfers would increase efficiency of operation. We have no objection to this proposal.

Mr. Chairman, we have one final suggestion with respect to the pending bill.

In 1977 (First Session of the 95th Congress), acting upon the recommendation of the House Veterans Affairs Committee, the House of Representatives gave overwhelming approval to H.R. 6501, a bill that proposed to amend Section 360, Title 38, USC, and thereby extend the principle of "paired organ involvement" to those veterans who are service-connected disabled for the loss or loss of use of one extremity and who subsequently incur the nonservice-connected loss or loss of use of the remaining paired extremity (Section 360 now addresses the disabilities of loss of sight, kidney function or hearing).

The Senate failed to act on this legislation.

More recently, in 1985, during the First Session of the 99th Congress, the full House of Representatives, again acting upon the recommendation of the House Veterans Affairs Committee, gave approval to H.R. 2343, which included among its provisions the "paired extremity" proposal.

The more recent bill is still pending in this body.

Mr. Chairman, we respectfully request and strongly urge that your Committee give favorable consideration to this most meritorious and modest goal (VA estimates only 64 severely disabled "paired extremity" veterans would be affected) by including it in any disability compensation increase bill favorably reported to the floor of the Senate.

## S. 2186 and S. 2187

The above cited measures, introduced by yourself, Mr. Chairman (S. 2186) and by Senator DeConcini (S. 2187), are very similar measures which, in combination, propose to exempt from any future "sequestration" of funds under Public Law 99-177, The Balanced Budget and Emergency Deficit Control Act of 1985, the VA programs of:

1. housing adaptation grants for service-connected disabled amputee, paralyzed and blinded veterans;
2. automobile and adaptive equipment awards for service-connected disabled amputee and blinded veterans; .
3. subsistence allowance payments to service-connected disabled veterans in vocational rehabilitation training;
4. educational payments to the dependents and survivors of totally disabled service-connected veterans and veterans whose deaths were related to a service-connected disability;
5. burial allowance payments to the survivors of veterans whose deaths were related to a service-connected disability; and
6. compensated work therapy payments to hospitalized service-connected disabled veterans.

Mr. Chairman, the DAV strongly supports enactment into law of the goals espoused by the pending bills.

Although full protection from Public Law 99-177 sequestration was given to VA disability compensation/pension COLAs, as well as "limited protection" to VA health care funding, nevertheless, "Gramm/Rudman/Hollings" has had a disastrous impact on the VA and its beneficiaries.

Specifically, the current sequestration order that went into effect on March 1, 1986 has led to the following:

1. special adapted housing grants cut by 7.9% -- a loss of some $2,800 and $475 for Section 801(a) and (b) grants, respectively;

2. automobile and adaptive equipment awards cut by 7.9% -- in the case of the one time automobile award, a loss of some $400;

3. vocational rehabilitation training allowances to service-connected disabled veterans cut by 13.1% -- the loss for a single veteran in full time training of $41 per month;

4. educational allowances for dependents and survivors of totally disabled veterans and veterans whose deaths were related to service-connected disabilities cut by 8.7% -- the loss of $33 per month for a trainee engaged in full time training; and

5. service-connected burial allowances cut by 7.75% -- an $85 reduction from the full grant.

Mr. Chairman, as you are well aware, VA benefit programs have experienced some $2 billion of benefit cutbacks since 1981. Notwithstanding the need to "balance the budget," nothing can countenance the above cited reductions -- all directly out of the existing benefit levels of the most severely disabled categories of service-connected veterans, their dependents and survivors.

Furthermore, there is no doubt in our minds that the Congress did not intend -- indeed, did not realize -- that "Gramm/Rudman/Hollings" would be applied in such a fashion to VA benefits and services. Nowhere is this more apparent than in the speedy action recently taken (by the Congress) to insure the continued viability of the VA's Home Loan Guaranty Program, once the impact of "G/R/H" became apparent.

Yes, Mr. Chairman, there is no doubt that the protection offered by S. 2186 and S. 2187 is most necessary and justified. We wish, however, to bring to your attention several concerns which relate to the pending bills.

First, we would note that the protection offered to service-connected disabled veterans engaged in vocational rehabilitation training varies under the pending bills: S. 2186 would offer such protection to only those trainees who are 50% or more service-connected disabled, while S. 2187 would protect the entitlements of all trainees.

We prefer the total protection offered by S. 2187 as, in our view, it would be basically inequitable to treat program beneficiaries in a dissimilar fashion...including some while excluding others. We cannot imagine the justification that would be given to a service-connected disabled below-the-knee amputee trainee (40% rating) that would convincingly explain why his classmate -- an above-the-knee service-connected disabled amputee (60% rating) -- is more deserving of full benefit entitlement.

We therefore recommend that the complete protection offered by S. 2187 be extended to all Chapter 31 trainees.

Our next concern relates to a recent communication which the DAV sent to VA Administrator Turnage wherein we expressed our grave reservations relative to the ongoing sequestration order of Public Law 99-177 and its impact on the granting of loans on veterans' insurance programs.

Specifically, we noted that the current sequestration order will impact upon the funds of the United States Government Life Insurance (USGLI), Veterans Reopened Insurance (VRI) and Service-Disabled Veterans Insurance (S-DVI) programs...requiring that policyholder borrowing be reduced from the present 94% of reserve value to 10% (USGLI), 59% (VRI), and 75% (S-DVI).

We pointed out to the Administrator the existence of a VA General Counsel Opinion which clearly finds such a sequestration to be:

> "...an unjustified intrusion on vested property rights and...subject to challenge and violative of Fifth Amendment protections."

Administrator Turnage responded to us, stating that the ultimate authority for interpreting the Balanced Budget Act rests in the office of the Comptroller General of the United States. We then wrote to the Comptroller General, requesting that he exercise such authority, addressing the question of possible Constitutional violation to VA insurance programs.

Mr. Chairman, we are aware that the full Committee Chairmen and Ranking Minority Members of both Veterans Affairs Committees have requested similar action by the Comptroller General. However, whatever that opinion may state -- _if_ it is forthcoming -- we believe that prior contractual agreements between the government and veteran policyholders regarding the amounts that may be borrowed from veterans' insurance policies should be honored.

We therefore request that the pending bills be amended to include protection from sequestration for VA insurance programs.

One final comment, Mr. Chairman:

Although the pending bills would certainly protect the _future_ benefit entitlements of severely disabled service-connected veterans, their dependents and survivors from sequestration under Public Law 99-177, they offer no relief whatsoever to those who have already had their benefits reduced and to those who will incur such reductions through the end of the current Fiscal Year.

If we can agree that these reductions were not warranted and were not even intended by the Congress, then why should we "write off" as a lost cause, the $2,800 housing adaptation grant reduction that was incurred by a double amputee veteran? Why should we simply "sympathize" -- and do nothing else -- with the paraplegic veteran whose one time automobile grant came up $400 short?

Mr. Chairman, if the Congress is going to provide redress for this inequity, then such redress should reach all program beneficiaries. We therefore urge and strongly recommend that the subject legislation be amended to require the Veterans Administration, upon termination of the current Fiscal Year, to identify those beneficiaries in the above cited programs who have incurred benefit reductions during the period March 1 through September 30, 1986 and, so identified, fully restore all portions of reduced entitlements.

In view of our previously stated willingness to forego hundreds of millions of dollars in Fiscal Year 1987 COLA adjustments (if applied equally to all federal beneficiaries), we do feel that this request for restoration of lost benefit entitlements cannot be viewed as excessive or unjustified.

## Draft Bill Relating to Future "Sequestration" of VA Benefits

Mr. Chairman, you have included on the hearing agenda a draft bill, authored by Senator DeConcini, which would require that specific VA programs be exempted from a future sequestration order under Public Law 99-177 -- and any such similar law that may be approved by the Congress -- unless such VA programs are specifically mentioned.

The VA benefits listed in the draft bill are·

1. service-connected burial allowance payments;
2. special adapted housing grants and mortgage protection life insurance;
3. educational benefits under Chapter 31, Title 38, USC;
4. educational benefits under Chapter 35, Title 38, USC;
5. automobile and adaptive equipment awards;
6. VA life insurance program policy loans;
7. home loan guaranty benefits; and
8. revolving funds associated with the canteen service and special therapeutic and rehabilitation activities.

Mr. Chairman, the DAV strongly applauds and supports Senator DeConcini's initiative.

While the proposal would not exclude any VA benefit program from the impact of sequestering under broad "economy" measures such as "G/R/H," it would require the Congress to specifically state its intention to include them, thereby directly addressing the issue. Such a requirement would very definitely insure that sweeping reductions of the type set into motion by "G/R/H" would only be applied where Congress intended them to be applied and would negate the necessity for "remedial" actions as recently experienced in the VA's Home Loan Guaranty Program.

We have one suggestion, however, and that is to include in the draft measure the existing benefit levels and future COLA adjustments in the VA's service-connected disability/death and nonservice-connected pension/death pension programs.

So amended, we urge the Committee's favorable consideration of the pending draft bill.

## S. 2168

This measure, introduced in the Senate by Senator Thurmond, proposes, through appropriate amendment of Section 312(b) of Title 38, USC, to add "organic residuals of frostbite" and "traumatic arthritis" to the list of diseases and conditions which, if diagnosed to a compensably disabling degree subsequent to the military service of a veteran who was interned as a prisoner-of-war for not less than 30 days, shall be presumed to be service-connected (subject to the limitations of Section 313, Title 38, USC).

Mr. Chairman, the DAV fully supports S. 2168.

This Committee is well aware of the "unique" nature of a POW experience and the great difficulty that former POWs have had, and continue to have, in establishing claims for service-connection of disabilities. This realization, of course, is a basis for the special consideration that is now afforded to former POWs under Section 312(b).

There are presently some 83,000 living former prisoners-of-war. Only a few of that number would be affected by the provisions of the pending bill. We certainly urge the Committee to give S. 2168 speedy and favorable consideration.

## S. 2304

Mr. Chairman, S. 2304, introduced in the Senate by Senator Cranston and cosponsored by Senators Matsunaga, DeConcini, Mitchell and Rockefeller, propose to extend the period of time during which a veteran may apply for employment in the federal government under Veterans' Readjustment Appointment (VRA) authority from September 30, 1986 to September 30, 1989.

Mr. Chairman, the DAV supports this proposed extension. As the Committee may be aware, Mr. Ron Drach, DAV National Employment Director, shall submit for inclusion in the hearing record additional comments relative to S. 2304 and related veterans' employment issues.

* * *

Mr. Chairman, this completes my statement. I again want to thank you and the Committee for extending us the opportunity to participate in today's proceedings.

STATEMENT OF
RONALD W. DRACH
NATIONAL EMPLOYMENT DIRECTOR
DISABLED AMERICAN VETERANS
TO THE
SENATE VETERANS AFFAIRS COMMITTEE
May 20, 1986

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

The Disabled American Veterans is very concerned that in spite of basic veterans' preference as contained in federal statute and codified in Title 5, U.S. Code (often perceived by many as being "absolute" and a deterrent to the federal government's efforts in hiring other disadvantaged groups) and the affirmative action provisions of Section 2014 of Title 38, U.S. Code, disabled veterans still do not enjoy large percentages of federal jobs.

As you may recall, several years ago, the Carter Administration attempted to severely curtail veterans' preference for Vietnam Era veterans, as a part of an overall effort to reform the civil service system. This effort ultimately resulted in Congressional passage of the Civil Service Reform Act of 1978. As approved, the Act retained, for the most part, both the 5 point and 10 point preference for wartime and disabled veterans and extended additional protection to veterans who have service-connected disability ratings of 30% or more. For example, agencies cannot deny these individuals employment based on disability without first providing justification to the Office of Personnel Management.

Also, the Civil Service Reform Act added Section 3112 to Title 5, U.S. Code and authorized the noncompetitive appointments of disabled veterans with a compensable service-connected disability of 30% or more. Although this authority has been in existence since 1978 and provides an excellent tool for federal agencies to increase their disabled veteran employee population, that authority has been grossly underused. I will discuss this in more detail later. These positive changes were the result of Senator Cranston's initiatives.

## VETERANS' READJUSTMENT APPOINTMENTS (VRA)

Mr. Chairman, the DAV believes that the VRA has been, and continues to be, an excellent authority which has opened up federal employment opportunities that otherwise may not have been available for Vietnam Era veterans. Since the establishement of this program by Executive Order in 1968, approximately 250,000 Vietnam Era veterans have obtained employment utilizing the VRA. Of those, more than 80% have been converted to career status. As of September 30, 1985, there were 51,786 Vietnam Era veterans identified as being employed under that authority.

Mr. Chairman, we do support the extension of the VRA expiration date to at least September 30, 1989. However, we support the House version extending it until December 31, 1991. The following data on VRA is provided for comparison.

VRA APPOINTMENT ON BOARD AS OF SEPTEMBER 30, 1985

| | | |
|---|---|---|
| All Agencies | 51,786 | (2.5%) |
| Total Defense Agencies | 37,030 | (3.7%) |
| Dept. of Labor | 64 | (.3%) |
| Dept. of Education | 5 | (.1%) |
| Dept. of HHS | 188 | (.1%) |
| OPM | 32 | (.5%) |
| VA | 10,356 | (4.2%) |

## DISABLED VETERANS AFFIRMATIVE ACTION PROGRAM (DVAAP--SECTION 2014, TITLE 38, U.S. CODE)

Mr. Chairman, Section 2014 of Title 38, U.S. Code, among other things, requires federal departments and agencies to have an affirmative action plan to employ and advance in employment qualified disabled veterans. The following data compares total employment with that of disabled veterans.

**DISABLED VETERANS AS A % OF THE WORKFORCE**
**AS OF SEPTEMBER 30, 1985**

| | Total | Total Disabled Veterans | 30% Or More Disabled Vets. |
|---|---|---|---|
| All Agencies | 2,830,910 | 175,620 (6.2%) | 40,263 (1.4%) |
| *ATBCB | 39 | 0 | 0 |
| Comm. on Civil Rights | 198 | 0 | 0 |
| Dept. of Air Force | 224,234 | 17,239 (7.7%) | 4,407 (2.0%) |
| Dept. of Army | 355,522 | 24,279 (6.8%) | 7,431 (2.1%) |
| Dept. of Education | 5,033 | 110 (2.2%) | 44 (.9%) |
| Dept. of HHS | 136,523 | 2,085 (1.5%) | 332 (.2%) |
| Dept. of Labor | 18,611 | 860 (4.6%) | 240 (1.3%) |
| Dept. of Navy | 333,487 | 15,666 (4.7%) | 3,811 (1.1%) |
| OPM | 6,629 | 194 (2.9%) | 57 (.9%) |
| VA | 248,409 | 12,483 (5.0%) | 3,957 (1.6%) |
| USPS | 716,260 | 80,271 (11.2%) | 15,557 (2.2%) |

* Architectural Transportation Barrier Compliance Board

Mr. Chairman, we are not impressed with the efforts of these agencies. These data reveal the number of disabled veterans hired, but no data exists to measure an agency's record regarding advancement. We are concerned that, in spite of the statutory requirement that federal departments and agencies take affirmative action to employ and "advance in employment" qualified disabled veterans, no ongoing mechanism exists to measure an agency's response to these requirements.

We are well aware that the Office of Personnel Management has the responsibility for the affirmative action provision of Section 2014, Title 38, U.S. Code, as they relate to disabled veterans. We suggest that OPM independently or in consultation with other agencies develop an effective system of evaluating agencies' records of upward mobility. This could be done administratively, but we ask you to consider a legislative mandate requiring the compilation of such data.

Perhaps the biggest deterrent to full realization of Congressional intent in DVAAP is the fact that no remedies are available to correct deficient affirmative action programs and plans.

Individual relief is available only through the EEO process within the agency and through the EEOC and/or MSPB appellate process. In my opinion, these systems are less than adequate. For example, an individual disabled veteran filed an original complaint of discrimination based on disability on June 21, 1979. The complaint was pursued through all the administrative levels and on March 23, 1983, EEOC's Office of Review and Appeals acknowledged receipt of this disabled veteran's complaint. I am appalled to report to you that more than three years after that receipt, this individual complaint still has not been resolved. This is perhaps a classic example of the legal adage, "justice delayed is justice denied."

## OFFICE OF PERSONNEL MANAGEMENT POLICIES

Mr. Chairman, with the resignation of Dr. Donald Devine as Director of OPM, we do not see quite the same level of open support for veterans' programs. For example, during Dr. Devine's tenure, FPM letters, memoranda and other communications were often sent to the agencies reminding them of their obligations. This type of oversight and supervision is no longer occurring.

We are appreciative of a recent letter from Assistant Director for Affirmative Employment Programs Robert Martinez to all departments and agencies advising them of the correct use of the veterans appointing authorities. We do believe, however, that OPM needs to take more aggressive actions to remind agencies of and hold them accountable for their requirements to comply with basic veterans' preference as codified in Title 5, U.S. Code...their affirmative action requirements both to employ and advance in employment qualified disabled veterans and to take steps to develop an effective enforcement mechanism.

## SECTION 3312, TITLE 5, U.S. CODE

During the Civil Service reform debate in 1978, Congress saw fit to add additional protections against discrimination based on disability for veterans. This protection was added as Section 3312(b) of Title 5, U.S. Code by the Civil Service Reform Act of 1978. Its provisions prohibit a federal agency or department from denying employment to a compensably service-connected disabled veteran (with a 30% or more rating) based on physical requirements, without first notifying the Office of Personnel Management and the preference eligible. The job must be held open pending a final determination by OPM.

The Disabled American Veterans is certainly supportive of this procedure, yet little, if any, implementation exists. Though the mandate is there, OPM apparently has not developed a way of monitoring agencies' activities to assure their compliance. Rather, they rely on the good faith of the agencies to comply "voluntarily." While we have no evidence to show that agencies are intentionally violating this provision, we do believe that some agencies may unintentionally violate it through omission -- simply not informing new personnel of its existence. At least two cases have recently come to our attention regarding the Postal Service and their failure to comply with Section 3312(b).

Set forth below are data recently received from OPM regarding the number of agency requests.

## SECTION 3312(b)
## REQUESTS FOR PASSOVERS ON MEDICAL REASONS

Non Postal Agencies

| Year | Requests | Sustained | Overruled | Cancelled |
|---|---|---|---|---|
| FY 1983 | 53 | 40 | 13 | |
| FY 1984 | | NOT AVAILABLE | | |
| FY 1985 | 55 | 47 | 5 | 4 |
| FY 1986 YTD | 23 | 21 | 2 | |

U.S. Postal Service

| Year | Requests | Sustained | Overruled | Cancelled |
|---|---|---|---|---|
| FY 1983 | 674 | 615 | 59 | |
| FY 1984 | | NOT AVAILABLE | | |
| FY 1985 | 470 | 391 | 31 | 8 |
| FY 1986 (1/24/86) | 147 | 139 | 8 | |

Regrettably, the data for Fiscal Year 1979 through Fiscal Year 1982 were not easily retrievable, thus OPM provided the data from FY 1983 through the first week of March, 1986.

We do believe that Director Horner should send out a reminder to all personnel directors of the importance of this program. We also believe that OPM should develop an ongoing monitoring device to assure that agencies are aware of and complying with this requirement.

## SECTION 3112, TITLE 5, U.S. CODE

Mr. Chairman, the Civil Service Reform Act also added a new noncompetitive appointing authority for disabled veterans who have a compensable service-connected disability of 30% or more. This appointing authority is codified in Section 3112, Title 5, U.S. Code and it offers federal departments and agencies an excellent tool to appoint qualified disabled veterans to available positions.

Regrettably, Mr. Chairman, this program has not realized its full potential. We believe, based on data available through September 30, 1985, more needs to be done in this program. The following data reports select agencies' records in using this authority. I would like to point out that the Department of Labor has made only three such appointments, as has the Department of Health and Human Services. Those agencies have a total civilian employment complement of 18,611 and 136,523, respectively.

NONCOMPETITIVE APPOINTMENTS OF 30% OR MORE DISABLED VETERANS AS OF SEPTEMBER 30, 1986

| | |
|---|---|
| All Agencies | 1,216 (.04%) |
| *ATBCB | 0 |
| Comm. on Civil Rights | 0 |
| Dept. of Air Force | 164 (.1%) |
| Dept. of Army | 398 (.1%) |
| Dept. of Education | 0 |
| Dept. of HHS | 3 (.002%) |
| Dept. of Labor | 3 (.02%) |
| Dept. of Navy | 256 (.1%) |
| OPM | 0 |
| VA | 301 (.1%) |
| USPS | 0 |

* Architectural Transportation Barrier Compliance Board

Mr. Chairman, total federal government noncompetitive appointments of disabled veterans total 1,216 and represent .04% of the overall work-force. Clearly, much more needs to be done.

Mr. Chairman, thank you for allowing the DAV the opportunity to provide you our views on these important issues.

Statement of

DAVID J. PASSAMANECK

AMVETS National Legislative Director

Before The

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

On

Cost of Living Increase for Compensation and DIC

May 14, 1986

AMVETS is pleased to present its views regarding the approximately 3.4% across the board cost of living increase in compensation for service connected disabilities and dependent's indemnity compensation set forth in proposed draft legislation.

We enthusiastically support this legislation, the purpose of which is to preserve the true value of disability compensation in the face of continuing, although diminishing inflation. We particularly appreciate the exemption of these unique entitlements from the indiscriminate Gramm-Rudman cuts. It is terribly unfortunate that the Armed Services Committees of both houses of Congress could not have thus far shown the same consideration for our military careerists, whose COLA was the first sacrifice on the Gramm-Rudman chopping block.

Similar legislation on a compensation COLA has been, or will be introduced in both houses of Congress with a variance of a fraction of a point increase, in each case tied to the amount of the automatic Social Security increase. We believe that the increase should be no more and no less than the actual increase in cost of living employed to trigger the Social Security increase, or, if below the level which would cause a Social Security increase that that actual increase in cost of living be applied to Compensation and DIC. We are opposed to artificial increases above the actual cost of living increase, for Social Security or VA compensation. We must remember that the exemption of Compensation from Gramm-Rudman imposes a proportionately greater burden on the medical and administrative portions of the VA budget. We know the sad condition of those elements, and we do not want to see unnecessary and unjustified increases eating further into their diminished recourses.

We support the debt collection amendments set forth in the draft legislation. However, as we have for many years, we urge the enactment of legislation exempting military longevity retired and retainer pay from offset by VA compensation. There is absolutely no justification for denying military retirees the incremental benefit of earned VA compensation because they have also earned retired pay through dedicated career service in the military.

This concludes my testimony. I will be pleased to respond to questions.

Statement of

DAVID J. PASSAMANECK

AMVETS National Legislative Director

Before The

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ON

S. 2445, S. 2174, S. 2388, S. 2304, S. 2168, S. 2186 and S. 2423

9:30 a.m., May 20, 1986 - Room SR 418

Mr. Chairman, AMVETS appreciates the opportunity to address the proposed "Veterans' Health Care Programs Improvements Act of 1986", (S.2445) which you have introduced; S. 2174, a bill to amend Title 38, United States Code, to require that non-Federal providers of hospital care and services receiving direct payment of Medicare funds for services to Medicare beneficiaries provide similar services to Veterans' Administration beneficiaries under similar Veterans' Administration payment policies; and S. 2388, the proposed "Veterans' Administration Health-Care Programs Extension and Improvement Act of 1986."

Regarding proposals for the provision of respite care as set forth in both S. 2445 and S.2388 introduced by Senator Cranston, AMVETS generally agrees with the need for such a program, both from the point of view of cost-effectiveness and compassion. Every effort should be made to encourage a maximum of home health care consistent with the medical needs of individual veterans. Each of the two bills under consideration here, together with similar legislation pending in the House of Representatives, has meritorious provisions. We endorse the concept, but offer the caveat that these suggested programs and the one to ultimately emerge in a public law in no sense give leverage to those who would curtail or further impair the provision of adequate hospital, nursing home and domiciliary care. To insure that the respite care alternative not have a deleterious effect on hospital, nursing and domiciliary care, the veteran should be given an ultimate option of choice between nursing, domiciliary and respite care, where all forms are available. Veterans should not be turned away from nursing homes and domiciliaries involuntarily, if they require the degree of attention which would justify respite care.

We also endorse Section 8 of S. 2388, for pilot studies of alternatives to institutional medical care, as we previously endorsed Section 9 of S. 6 and Section 2 of S. 876 introduced by Senator Cranston and the Chairman, respectively, and H.R. 505. We also support the provisions in S. 2445 for "case management" of chronically mentally ill veterans in contracted facilities, with the same caveat as applies to respite care.

The flexibility which Section 7 of S. 2445 would provide in granting funds for state homes is a practical measure which would expedite construction as funds become available.

AMVETS has never put unquestioning faith in the efficacy of the arbitrary bed limits and minimal requirements of Section 5010 of Title 38. We are more interested in the adequate provision of care, rather than playing a numbers game which rarely results in actually affecting the quality of that care. As to whether or not the minimal requirement for operating beds include domiciliary beds, we would prefer to suspend judgment at this time.

We appreciate the introduction of S. 2304 to extend for 3 years the authority to make veterans readjustment appointments as set forth in Section 2014(b) of Title 38. We also concur with extending benefits for ex-POW's as provided in S. 2168.

The legislation introduced by the Chairman (S. 2186) and Senator DeConcini (S. 2423) to exempt various VA programs from the impact of Gramm-Rudman are justified as providing a minimum standard of moral integrity. We advocate, however, complete exemption of all budget items relating to national defense, including the VA budget in its entirety. Let's try to save money on some of the 40 programs which the Senate, as of now, refuses to eliminate as requested by the President, before we chip away at veterans or our chances for survival.

The purpose of S. 2174 seems to be practical and justified. Certainly the DRG system should govern VA costs for the provision of medical care by non-federal facilities on contract, and we can see no reason why we should not use the proportionately much greater Medicare constituency as a wedge to require private providers to afford the same terms to the VA. We understand that S. 2174 is not intended as a step toward merging the VA health care system with Medicare, or as a basis for undue expansion of the non-federal contracting system to the detriment of the VA operated system.

We appreciate the concern reflected in Senator Cranston's proposal to expand eligibility for readjustment and extend counseling service to bereaved survivors of veterans who had been receiving mental health services prior to their death. AMVETS would, however, open the eligibility for readjustment counseling to all combat veterans. The time for special treatment of Vietnam veterans is or should be drawing to a close and we believe this service, which has certainly proven its worth, should be generally available. Regarding bereavement counseling, we would reserve judgment, pending a more thorough appreciation of costs involved. This is no time to be significantly expanding costs at the possible expense of other programs or risking the credibility of the total structure of VA programs.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

BOB MORAN, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE

THE SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

THE VA'S COMPENSATION PROGRAMS (S.2422),

VARIOUS HEALTH RELATED ISSUES, AND OTHER PROVISIONS

MAY 20, 1986

Mr. Chairman and Members of the Committee, it is a privilege and pleasure for me to appear here today and present the views and concerns of Paralyzed Veterans of America on the Compensation and Dependency and Indemnity Compensation (DIC) programs administered by the Veterans Administration and on various health issues of importance to our members. I am Bob Moran, Associate Legislative Director of Paralyzed Veterans of America.

Initially, I want to extend PVA's appreciation to you, Mr. Chairman and Members of this Committee, for your ongoing efforts to improve these most important programs that directly affect PVA's members and their dependents, and for allowing PVA to testify and work with you and your professional staff in these important endeavors.

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300

## Veterans Disability Compensation and DIC

The proposal, S.2422, the "Veterans' Compensation and Benefits Improvements Act of 1986," would provide for an increase in the rates of compensation paid to veterans for their service-connected disabilities and in the rates of Dependency and Indemnity Compensation (DIC) paid their survivors. PVA supports S.2422 and its proposed 3.4 percent increase in the rates of veterans disability compensation, and DIC, which would be effective December 1, 1986. We have always supported a viable compensation program to care for this nation's service-connected disabled veterans and their families.

Congress created the compensation program for veterans to provide for the loss of earning capacity, when the diminished capacity results from injury or illness incurred while in service to the nation. Compensation is for many of PVA's members extremely important, because for many catastrophically disabled veterans it remains their primary source of income. Therefore, we firmly believe that service-connected disability compensation and DIC should be adjusted each year to offset the effects of erosion caused by inflation.

Concerning Section 303 of S.2422, PVA does not support pay parking at Veterans Administration facilities for our Nation's veterans. This is not to say that the concept of pay parking at VA facilities should not be explored. Also, any efforts to charge veterans for parking would prove to be totally incompatible with the mission of the VA. In a society almost wholly dependent on the automobile for transportation, parking is an integral part of access to the VA health-care system. With the absence of mainline, accessible mass transit in most areas, the privately owned vehicle is indispensable for access to the system for both veterans and employees alike. Additionally, with collocation of VA medical centers and regional offices being considered for expanded utilization, the implementation of pay parking would further serve to restrict access to the full range of veterans' benefits and services.

In light of current budget constraints, it has become apparent that the funding for the construction of new parking facilities is being viewed as a low priority, and that alternative methods of funding need to be explored. PVA recognizes the need to explore alternative methods of funding, and agrees with the Committee in examining the use of the revolving fund approach as a possible solution to this dilemma.

For example, in the event that a new parking facility is needed at an already existing VAMC structure, and no federal funds are available for its construction, PVA believes that the VA should create a revolving fund to be used solely for the purpose of that project. Parking fees should be based on reasonable and customary charges in that particular geographical location and fees should cease when the project is paid for.

PVA believes the VA should first charge visitors, and should it be assessed that additional revenue is necessary in order to pay for the construction completion within a reasonable amount of time, employees of the VA should next be charged. However, if employees are required to pay a fee for parking, PVA would encourage some other type of recruitment and retention compensation incentive. The purpose of addressing this particular concern is to assure the continued retention and future recruitment of high quality medical personnel.

PVA also supports S.2187, a measure to exempt from any requirement for sequestration of appropriated funds, amounts available to provide certain benefits to veterans with service-connected disability. With the passage of Public Law 99-177, the "Balanced Budget and Emergency Deficit Control Act of 1985," certain essential and critical benefits to service-connected veterans were callously reduced; we each know what benefits were cut by the VA and by how much in order to meet their first sequestration mandate, but for the sake of the record I would like to list them again. They are:

1. Special adaptive housing grants cut by $2840, from $35,500 to $32,660;
2. Automobile and adaptive equipment awards cut by 7.9%, the one time car grant cut $400;
3. Vocational rehabilitation training allowances to service-connected disabled veterans cut by 13.1%;
4. Educational allowances for dependents and survivors of totally disabled veterans whose deaths were related to service-connected disabilities cut by 8.7% ;
5. Service-connected burial allowances cut by 7.7%.

Mr. Chairman, PVA, as an organization, represents these veterans. We are comprised totally of the most catastrophically-disabled veterans; a population who was profoundly affected by the gross reductions in the programs we have just outlined. These cuts were levied upon the most severely disabled categories of service-connected veterans, and their dependents and survivors. This should not have happened and must not happen again.

PVA believes that the cuts made to these service-connected veterans' benefits were not what the Congress envisioned with passage of P.L. 99-177. PVA hopes that with the passage of S.2187, these programs will be exempt from any further reduction from possible sequestration in the future.

It should be remembered that spinal cord injured veterans, as well as many others with mobility impairments, rely heavily upon many of these benefits in order to maintain a significant level of independence and control over their environment. PVA believes that a reduction in these basic and essential benefits violates the veteran's right to an affordable, adaptable and barrier-free environment, and would therefore decreases his level of functional independence. This is wrong and the VA should be made aware of its misguided effort.

In regard to burial benefits for veterans who die as a result of a service-connected disability, PVA believes that these families deserve assistance and protection from undue financial strain. The hardship associated with death of a family member as a result of service-connected disability need not be further compounded by the inability to defray the cost of burial. PVA believes it is the mission of the VA to provide adequate burial benefits for these veterans.

Further, PVA believes it is the mission of the VA to promote on-going assistance to survivors and dependents of veterans who die from service-connected disabilities. The ability to pursue educational advancement is an integral part of assistance provided families of deceased service-connected veterans.

Regarding assistance given to train and rehabilitate veterans with service-connected disabilities, PVA believes that subsistence allowances are a critical element in the veteran's ability to successfully participate in the training and rehabilitation program, (Chapter 31). We further believe that the participation in such a program is essential to the improvement of the veteran's quality of life for himself and his family.

## Health Care Issues

I would now like to present to you the views and concerns of PVA regarding the health-care legislative proposals being discussed today. I should point out that our testimony will not seek to address all aspects of each bill, rather we will restrict our comments to those specific matters that have direct implication in meeting the unique needs of PVA's membership.

Before going into specifics on the proposed legislation, PVA would like to commend you, Chairman Murkowski and you, Senator Cranston for your obvious devotion and leadership in continually attempting to improve both the quality and delivery of what PVA considers to be the most important veteran benefit, quality health care. Like you, PVA seeks to secure through the Veterans Administration, the very best, the most compassionate, and the most comprehensive medical care services this nation can provide. This being our common goal, I am pleased to proceed.

With regard to S.2174, PVA believes that accessibility to quality medical care is the right of all veterans, regardless of their geographic location. While we support that the majority of this care be maintained in VA facilities, we recognize the need to utilize non-VA facilities in certain instances. Therefore, we support any measure deemed necessary to continue the provision of this essential service.

In keeping with our mutual goal of quality health-care, PVA is pleased to endorse certain provisions of S.2388, a bill introduced by Senator Alan Cranston and certain provisions of S.2445, introduced by you, Mr. Chairman. Once again, PVA will defer judgement on provisions which do not directly impact on our membership.

PVA would like to thank both you Mr. Chairman, and you, Senator Cranston, for the inclusion of respite care in your respective bills. We have been a long and ardent advocate of the need for the VA to provide this most necessary and important service to veterans, including PVA's members, who suffer from chronic medical conditions requiring continual and constant supervision and care. PVA has previously documented its support of this cost-effective, humane and greatly appreciated form of veterans' health care on April 22, 1986, before the House Subcommittee on Hospitals and Health Care.

Our major concern with the respite care provisions in both bills is the requirement that the respite care be furnished in a VA hospital or nursing home. Most individuals with chronic conditions can and do live outside the permanent confines of a hospital or nursing home setting. PVA promotes the concept of its members obtaining and maintaining optimum levels of independence afforded by living in the community. For our members with chronic and catastrophic disabilities it is often a life of dependence upon one's family or primary caregiver to maintain a life outside of an institutional environment. The simple provision of an opportunity for respite care can often mean the difference of a veteran having to choose between life within an institution or in the community at large.

We wholeheartedly support the concept of respite care, but believe that the veteran be able to choose whether that care be offered in a VA institution or be provided such necessary health care services in his home. We believe that for certain veterans, admission to an institution would represent an unnecessary disruption in their lives and require the temporary yielding of a certain amount of independence. PVA encourages this Committee to consider adding home health care as another viable means of providing the type of assistance intended by respite care. PVA believes that whether respite care is required to undergo pilot program testing, or is simply enacted into law, it will prove to be a valuable and cost-effective alternative to institutionalization and a humane service to veterans and their families.

PVA is particularly pleased to address Senator Cranston's provision for procreative services to overcome service-connected disabilities preventing pregnancy. All of PVA's members are veterans who have experienced spinal cord injury or dysfunction, and SCI can and often does result in a residual loss of procreative ability as a secondary impairment from the primary injury. Consequently, we are concerned that in accordance with this provision, that Title 38 be amended to also include veterans whose procreative disability is a secondary and functional impairment resulting from a primary disability, as is common in spinal cord injury. We believe this to be a necessary and essential clarification.

For many of our members, the inability to experience the fullness of life brought about by the growth and expansion of one's immediate family has been a major psychological barrier. PVA's members are faced first with a catastrophic disability and then with the realization that this disability could deny them one of society's greatest rewards, children.

PVA has, since the formation of its first chapter nearly forty years ago, been an advocate for the expansion of roles for the disabled. Today, with ever expanding medical technology, our members can expand their roles even further, as fathers, mothers, grandfathers and grandmothers. We believe that parenting is a very personal choice, and our members should have that choice. Further, PVA believes that intercession on the part of the VA in this issue is a matter of preservation of human rights. We ask that every member of Congress act to preserve that right and in so doing, add another ray of hope to the life of the catastrophically disabled. PVA has for a long time been an advocate of this service and would be happy to provide any advice or assistance as it relates specifically to our membership.

PVA is also pleased to support Senator Cranston's provision for bereavement counseling for family members and significant others of the veteran. PVA's experience with long-term disabilities emphasizes the important roles these people fulfill in the lives of catastrophically disabled veterans and the significance of their emotional well-being.

PVA also supports the provision in S.2388 which provides extension of eligibility for domiciliary care to veterans who are incapacitated from earning a living and have no adequate means of support.

In light of soaring health-care costs and studies indicating the advantages of non-institutional care, PVA applauds legislation which provides alternatives to hospital or nursing home care. However, PVA believes that the VA should, whenever possible, be the provider of these services. Therefore, we encourage the VA to continue to expand its current role in this effort.

PVA believes that in the instance of hospital-based home care, the hospital base should be a VA facility and the VA should encourage expansion of its present program. With regard to contract services of this nature, PVA recommends that home care programs not be limited to hospital-based home care, but also include the feasibility of contracting with the many non-hospital based private sector initiatives currently available.

PVA would like to emphasize the importance of the role of the VA in providing "case management" and oversight responsibilities to ensure quality contract services. If it is the opinion of the Committee that this oversight function could be most efficiently carried out through the initial piloting of these services, PVA would support such a pilot. We believe that providing alternatives to institutionalization through home care, respite care and independent living centers and other programs will maximize the veteran's independence and prove to be cost-effective, so long as the programs do not limit or reduce other existing programs.

PVA does support the extension of the VA authority to maintain a facility in the Philippines. We think it important to maintain the stability of that entity in light of the current changes that are occurring for this important ally of the United States.

PVA also supports the provisions within your bill, Mr. Chairman, S. 2445, which would require the VA to prioritize State Home Grants and the funding for such projects. We think the proposals being made should go far toward bringing the State Home Construction Grant Program into a more systematic and evaluative process based more upon the actual needs of a given state rather than by the somewhat restrictive method presently being used.

We also like the idea of the VA Administrator submitting criteria and procedures to establish a priority list of state home construction grant projects, prioritized based upon relative need. We think it most appropriate that such a list be submitted to Congress at the same time the President's budget is presented, therefore allowing for this grant program to be viewed in its proper perspective along with the total operating budget of the VA. The prioritized listing of construction projects should also go far in giving actual legitimacy to a given project's need and taking it out of the arena which it has often time fallen into -- that of selection determined by desire, not necessarily greatest need.

PVA does not support Section 6 of S.2445, which would add domiciliary beds to the total number of beds operating within VA Medical Facilities. Changing the language of Section 5010, Title 38, by adding domiciliary beds with hospital beds and nursing home beds, would ultimately lead to a reduction in the overall VA bed availability. PVA opposes any legislation which reduces present health care resources to our nation's veterans.

Finally, PVA endorses the establishment of the Ionizing Radiation Registry. We recognize the potential impact of this relevant data and its potential for future research and health planning.

## Conclusion

Mr. Chairman and Members of the Committee, on behalf of the members of Paralyzed Veterans of America, I appreciate the time and attention given to our statement by the Members and staff of this Committee. This concludes my statement Mr. Chairman, and I will be glad to respond to any questions that you may have.

II

99TH CONGRESS
1ST SESSION

# S. 1536

To amend title 38, United States Code, to provide that per diem subsidies paid by the Veterans Administration for the care of veterans in State homes shall not be used to offset payments that are made under the medicaid program for the purpose of assisting eligible veterans.

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IN THE SENATE OF THE UNITED STATES

JULY 31 (legislative day, JULY 16), 1985

Mr. MITCHELL (for himself and Mr. COHEN) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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# A BILL

To amend title 38, United States Code, to provide that per diem subsidies paid by the Veterans Administration for the care of veterans in State homes shall not be used to offset payments that are made under the medicaid program for the purpose of assisting eligible veterans.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That section 641 of title 38, United States Code, is amended by adding at the end thereof the following new subsection:

"(d) Payments made to States pursuant to this section—

"(1) shall not be considered to be a third-party liability for any purpose under section 1902(a)(26) of title XIX of the Social Security Act; and

"(2) shall, for purposes of determining under title XIX of the Social Security Act the reasonable costs of services provided by a State home, not be deducted directly or indirectly from the operating or other costs of such State home.".

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II

99TH CONGRESS
2D SESSION

# S. 2168

To amend title 38, United States Code, to improve veterans' benefits for former prisoners of war.

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IN THE SENATE OF THE UNITED STATES

MARCH 10, 1986

Mr. THURMOND (for himself and Mr. HEINZ) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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# A BILL

To amend title 38, United States Code, to improve veterans' benefits for former prisoners of war.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That section 312(b) of title 38, United States Code, is amended by striking out "or" at the end of clause (9) and by inserting after clause (10) the following new clauses:

"(11) organic residuals of frostbite, or

"(12) arthritis resulting from trauma incurred while interned as a prisoner of war,".

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Office of the
Administrator
of Veterans Affairs

Veterans
Administration

JUL 23 1986

Honorable Frank H. Murkowski
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

We are pleased to respond to your request for a report on S. 2168, 99th Congress, a bill designed "to improve veterans' benefits for former POWs."

The bill, if enacted, would amend section 312(b) of title 38, United States Code, by adding two medical conditions to the list of those for which service connection is presumed if they are manifested to a compensable degree following service by veterans who were prisoners of war for at least thirty days. The additional conditions, as presented in the bill, are "organic residuals of frostbite" and "arthritis resulting from trauma incurred while interned as a prisoner of war."

For the reasons set forth below, we do not oppose enactment of S. 2168, although we consider it to be largely unnecessary.

The incorporation into section 312(b) of the provisions in question would not have a significant impact on current VA adjudicative practices. Direct service connection is routinely granted for frostbite residuals and traumatic arthritis, where they are shown to be related to service. If a prisoner of war developed either condition in conjunction with internment, the condition ordinarily would have manifested itself and required treatment upon repatriation or shortly thereafter. In the great majority of ex-POW cases, sufficient medical evidence would exist to establish incurrence in service without any need for a statutory presumption. Additionally, VA policy is to treat claims of former POWs in a liberal manner, giving special consideration to the hardships and privations they have endured and, of course, resolving any reasonable doubt in their favor.

On the other hand, we are mindful that some cases do not fit the norm. In particular, we are aware of the realities of the repatriation process and the initial tendency of many ex-POWs to put aside their traumatic experiences. This, in turn, can result in a lack of sufficient evidence to substantiate a claim filed some years later. We believe, therefore, that this legislation could serve as a "safety net" for some ex-POWs, facilitating grants of service connection well after service in some deserving cases.

Be that as it may, the provision in S. 2168 regarding traumatic arthritis is of concern to us from a technical standpoint. Strictly interpreted, it requires that the evidence show the arthritis resulted from trauma incurred during POW internment. The provision thus seems to create a redundancy, because such a requirement would satisfy already-existing law and establish service connection with no need to apply a presumption. In fact, the bill as drafted would preclude application of a presumption for traumatic arthritis.

We estimate that, if section 312(b) were amended in the manner presently proposed, it would entail insignificant costs to the Government.

Advice has been received from the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

THOMAS K. TURNAGE
Administrator

II

99TH CONGRESS
2D SESSION

# S. 2174

To amend title 38, United States Code, to require that non-Federal providers of hospital care and services receiving direct payment of Medicare funds for services to Medicare beneficiaries provide similar services to Veterans' Administration beneficiaries under similar Veterans' Administration payment policies.

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IN THE SENATE OF THE UNITED STATES

MARCH 11 (legislative day, MARCH 10), 1986

Mr. MURKOWSKI (by request) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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# A BILL

To amend title 38, United States Code, to require that non-Federal providers of hospital care and services receiving direct payment of Medicare funds for services to Medicare beneficiaries provide similar services to Veterans' Administration beneficiaries under similar Veterans' Administration payment policies.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That a new section 625 is added to subchapter III of chapter 17, which new section 625 reads as follows:

**"§ 625. Requirement that providers accept Medicare and Veterans' Administration beneficiaries on similar basis, and accept Veterans' Administration payments as payments in full**

"(a) For purposes of this Act, 'Veterans' Administration beneficiaries' means all veterans and other persons for whose hospital care outside Federal facilities the Veterans' Administration is authorized to pay.

"(b) Notwithstanding any other provision of this title or of title 42, United States Code, or other law, any non-Federal provider of hospital services to any Medicare beneficiary must also accept Veterans' Administration beneficiaries on a similar basis, and must accept payments made by the Veterans' Administration in accordance with Veterans' Administration regulations as payments in full.

"(c) Upon a finding by the Administrator, made in accordance with procedures developed in consultation with the Secretary of Health and Human Services, that a Medicare provider has failed to comply with this Act, the Administrator, if unable to obtain prompt corrective action, will report such finding to the Secretary for possible corrective action or for possible termination of the provider's agreement with the Secretary entered into pursuant to section 1395cc(a) of title 42, United States Code. Thereafter, in addition to the bases for termination set forth in section 1395cc(b) of title 42, United States Code, the Secretary may terminate such agreement with the provider if the Secretary determines that the provider has failed to comply with this Act.".

SEC. 2. The table of parts and chapters at the beginning of title 38, United States Code, and the table of sections at the beginning of chapter 17 of such title are each amended by inserting after

"624. Hospital care, medical services, and nursing home care abroad."

the following:

"625. Requirement that providers accept Medicare and Veterans' Administration beneficiaries on similar basis, and accept Veterans' Administration payments as payments in full.".

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Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUL 23 1985

Honorable George Bush
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

There is transmitted herewith a draft bill "To amend title 38, United States Code, to require that non-Federal providers of hospital care and services receiving direct payment of Medicare funds for services to Medicare beneficiaries provide similar services to VA beneficiaries under similar VA payment policies." We request that the bill be referred to the appropriate Committee and recommend its prompt enactment.

The purpose of this legislative proposal is to limit the increase in the costs to VA of our contract hospitalization program by requiring non-Federal providers that furnish hospital care and services to Medicare beneficiaries to provide similar services to VA beneficiaries, and to accept for such services VA payments made in accordance with VA regulations. The draft bill would authorize the termination of eligibility of a Medicare provider that either would not accept VA payments made in accordance with VA regulations or would not accept VA beneficiaries as patients on the same basis as Medicare beneficiaries.

This aim now has added importance, since the Medicare program has adopted a payment system based on paying predetermined dollar amounts for cases identified as falling within Diagnosis-Related Groups (DRGs) rather than paying for all or a specified part of the actual cost of the hospital care provided. The adoption by the Medicare program of this payment system already has achieved very substantial savings to the Government, and it clearly is in the Government's interest to use a similar system for paying the non-Federal hospital expenses of VA beneficiaries as in paying for Medicare beneficiaries.

The VA is promulgating regulations which will authorize the Agency to use a payment system, similar to that used by the Medicare program, based on paying predetermined dollar amounts for identified DRGs. Significant dollar savings are expected to result from implementation of this change in the method of paying for hospital services rendered by non-Federal providers to VA beneficiaries just as has occurred in the Medicare program. At the same time, it is recognized that the number of VA beneficiaries in non-Federal hospitals for whom VA will pay the costs of care is far less than the analogous number of Medicare beneficiaries paid for by Medicare, involving only about 30,000 episodes of non-VA hospital care nationwide. Our concern is that some non-Federal providers that have agreed to treat Medicare beneficiaries may nevertheless refuse to accept VA beneficiaries on a similar basis.

To help assure VA's use of a system similar to Medicare's for paying non-Federal providers of hospital services, the legislation proposed here would require that non-Federal providers of hospital care and services to Medicare beneficiaries must accept VA beneficiaries as patients to the same extent as Medicare beneficiaries, and must accept VA payments for their services to VA beneficiaries made in accordance with VA regulations as full payment for such services. Medicare beneficiaries to some extent are personally subject to deductibles, co-insurance, and other payments. Since VA beneficiaries are not personally subject to such deductibles, co-insurance, or other payments, the actual amounts paid by VA to such providers may to that extent exceed the amount which Medicare would pay such provider in a similar case.

The draft bill would also authorize the Administrator, upon finding noncompliance by a provider with this Act in accordance with procedures established by the Administrator after consulting the Secretary of Health and Human Services, to report such noncompliance to the Secretary. Only inpatient providers of hospital care or services who either refuse to accept VA beneficiaries as patients, or who refuse to accept VA payment in accordance with VA regulations as full payment for their services similar to the manner in which Medicare payments are accepted by such providers, would be considered not to be in compliance with this Act. The Secretary is authorized to arrange for prompt corrective action, or to terminate such provider's status as an eligible Medicare provider upon finding that such provider has failed to comply with the Act here proposed.

It is not possible to estimate the amount of cost savings which would be associated with the enactment of this legislative proposal. It is not known with any degree of specificity how many non-Federal inpatient providers of health services, absent this legislation, would not accept VA beneficiaries as patients if their payments by VA were limited to the amount set forth in VA regulations as payments in full. It is clear, however, that overall savings would result from this bill's enactment.

We have been advised by the Office of Management and Budget that there is no objection to the submission of this draft bill to the Congress, and its enactment would be consistent with the Administration's objectives.

Sincerely,

Harry N. Walters

HARRY N. WALTERS
Administrator

## SECTION-BY-SECTION ANALYSIS

Section 1 of this bill would amend title 38, United States Code, by adding new section 625, which would require non-Federal providers of hospital care and services to Medicare beneficiaries to provide similar services to VA beneficiaries and to accept VA payments made in accordance with VA regulations as payments in full for such services. Section 625 contains three subsections.

Subsection a. defines VA beneficiaries as persons for whose hospital care outside Federal facilities VA has been authorized to pay.

Subsection b. provides that any non-Federal provider of hospital care and services to Medicare beneficiaries must also accept VA beneficiaries on a similar basis, and must accept payments made by VA in accordance with VA regulations as payments in full.

Subsection c. provides discretionary authority for the Government to enforce new section 625. It authorizes the VA to prescribe procedures for identifying providers not in compliance with this Act, and authorizes the VA to report such noncompliance to the Secretary of Health and Human Services. The Secretary is then authorized to seek corrective action or to terminate that provider's agreement with the Medicare program, based on the provider's noncompliance with section 625.

Section 2 of the bill amends both the Table of Parts and Chapters at the beginning of title 38, and the table of sections at the beginning of chapter 17 by inserting references to proposed section 625 and its caption following the corresponding provisions of section 624.

Changes in existing law made by the draft bill are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is underscored, and existing law in which no change is proposed is shown in roman):

## TITLE 38--UNITED STATES CODE

## PART II-GENERAL BENEFITS

### CHAPTER 17.–HOSPITAL, DOMICILIARY, AND MEDICAL CARE

#### SUBCHAPTER I –GENERAL

Sec
601. Definitions
602. Presumption relating to psychosis

#### SUBCHAPTER II –HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

#### SUBCHAPTER III –MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

621. Power to make rules and regulations.
622. Statement under oath.
623. Furnishing of clothing
624 Hospital care, medical services and nursing home care abroad.

"§ 625. Requirement that Providers accept Medicare and VA Beneficiaries on Similar Basis, and accept VA payments as payments in full.

"(a) For purposes of this Act, "VA beneficiaries" means all veterans and other persons for whose hospital care outside Federal facilities VA is authorized to pay.

"(b) Notwithstanding any other provision of this title or of title 42, United States Code, or other law, any non-Federal provider of hospital services to any Medicare beneficiary must also accept VA beneficiaries on a similar basis, and must accept payments made by VA in accordance with VA regulations as payments in full.

"(c) Upon a finding by the Administrator, made in accordance with procedures developed in consultation with the Secretary of Health and Human Services, that a Medicare provider has failed to comply with this Act, the Administrator, if unable to obtain prompt corrective action, will report such finding to the Secretary for possible corrective action or for possible termination of the provider's agreement with the Secretary entered into pursuant to 42 U.S.C. § 1395cc(a). Thereafter, in addition to the bases for termination set forth in 42 U.S.C. § 1395cc(b), the Secretary may terminate such agreement with the provider if the Secretary determines that the provider has failed to comply with this Act."

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II

99TH CONGRESS
2D SESSION

# S. 2304

To amend title 38, United States Code, to extend the period of time during which veterans readjustment appointments may be made.

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## IN THE SENATE OF THE UNITED STATES

APRIL 15 (legislative day, APRIL 8), 1986

Mr. CRANSTON (for himself, Mr. MATSUNAGA, Mr. DECONCINI, Mr. MITCHELL, and Mr. ROCKEFELLER) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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# A BILL

To amend title 38, United States Code, to extend the period of time during which veterans readjustment appointments may be made.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That section 2014(b)(2) of title 38, United States Code, is amended by striking out "1986" and inserting in lieu thereof "1989".

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Office of the
Administrator
of Veterans Affairs

Veterans
Administration

JUL 1 4 1986

Honorable Frank H. Murkowski
Chairman, Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to provide the views of the Veterans Administration (VA) on S. 2304, 99th Congress, a bill "To amend title 38, United States Code, to extend the period of time during which veterans readjustment appointments may be made." The Veterans Administration strongly supports this proposal.

S. 2304 would extend for an additional three years, through September 30, 1989, the Veterans Readjustment Appointments (VRA) authority under section 2014 of title 38, United States Code. If not extended, this authority will expire at the end of this fiscal year. This authority allows Federal agencies to appoint noncompetitively qualified disabled and Vietnam-era veterans to civil service positions at a maximum GS-9 grade level. These appointments can then be converted to career or career-conditional appointments after two years of satisfactory employment and training.

VA is especially proud to be a leader in employing Vietnam-era veterans through the VRA authority. Since 1970, we have appointed more than 85,000 veterans under this authority in a wide variety of occupations.

The VRA authority has been very successful in meeting the goals of assisting disadvantaged and disabled veterans in gaining skills, training, and development to allow them to compete in the job market, secure employment, and enter the mainstream of American society. This authority has, in turn, been very beneficial to VA in obtaining necessary high-quality staff while providing many disabled and Vietnam-era veterans with an opportunity which has led to successful careers. In effect, this authority has provided VA and other agencies an expedited and simplified method for staffing vacancies, which saves recruiting time and maintains a high quality of job candidates. The three-year VRA authority extension, as proposed by S. 2304, would allow us to employ additional qualified disabled and Vietnam-era veterans.

2.

Honorable Frank H. Murkowski

Extending the VRA authority is essentially a cost-free method of helping reduce the unemployment rate of veterans. We do not anticipate that an extension of this authority would have any budgetary impact on VA. For these reasons, we urge that S. 2304 be enacted.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

THOMAS K. TURNAGE
Administrator

II

99TH CONGRESS
2D SESSION

# S. 2388

To amend title 38, United States Code, to improve various aspects of Veterans' Administration health-care programs, to provide eligibility to new categories of persons for readjustment counseling from the Veterans' Administration, to authorize the Administrator of Veterans' Affairs to establish programs for the furnishing of respite care to certain chronically ill service-connected disabled veterans and of noninstitutional care to certain veterans, to extend certain expiring authorities, and for other purposes

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IN THE SENATE OF THE UNITED STATES

APRIL 30 (legislative day, APRIL 28), 1986

Mr. CRANSTON introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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# A BILL

To amend title 38, United States Code, to improve various aspects of Veterans' Administration health-care programs, to provide eligibility to new categories of persons for readjustment counseling from the Veterans' Administration, to authorize the Administrator of Veterans' Affairs to establish programs for the furnishing of respite care to certain chronically ill service-connected disabled veterans and of noninstitutional care to certain veterans, to extend certain expiring authorities, and for other purposes

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That (a) this Act may be cited as the "Veterans' Administration Health-Care Programs Extension and Improvement Act of 1986".

(b) Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

ENFORCEMENT OF STATE AND LOCAL TRAFFIC LAWS BY VETERANS' ADMINISTRATION POLICE OFFICERS

SEC. 2. Paragraph (1) of section 218(b) is amended to read as follows:

"(1) Veterans' Administration employees who are Veterans' Administration police officers shall enforce, with respect to acts occurring on Veterans' Administration property—

(A) Federal laws;

(B) the rules prescribed under subsection (a)(2)(A) of this section; and

(C) traffic and motor vehicle laws of a State or local government which has jurisdiction over such Veterans' Administration property, pursuant to an express grant of authority under State or local law to enforce such laws, by issuing citations for violations thereof.

Subject to regulations prescribed under paragraph (2) of this subsection, a Veterans' Administration police officer may make an arrest on Veterans' Administration property for a violation of any Federal law or any such rule.".

### SERVICES TO OVERCOME SERVICE-CONNECTED DISABILITY AFFECTING PROCREATION

SEC. 3. Clause (A) of section 601(6) is amended to read as follows:

"(A)(i) surgical services, (ii) services to achieve pregnancy in a veteran or a veteran's spouse where such services are necessary to overcome a service-connected disability impairing the veteran's procreative ability, (iii) dental services and appliances as described in sections 610 and 612 of this title, (iv) optometric and podiatric services, (v) (in the case of a person otherwise receiving care or services under this chapter) preventive health-care services as defined in section 662 of this title, (vi) (except under the conditions described in section 612(f)(1)(A)(i) of this title) wheelchairs, artificial limbs, trusses and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Administrator determines to be reasonable and necessary, and (vii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and".

## CONTINUATION OF CERTAIN COUNSELING SERVICES FOR A DECEASED VETERAN'S FAMILY MEMBERS

SEC. 4. Clause (B) of section 601(6) is amended to read as follows:

"(B)(i) such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment—

"(I) of the service-connected disability of a veteran pursuant to section 612(a) of this title, and

"(II) in the discretion of the Administrator, of the non-service-connected disability of a veteran eligible for treatment under section 612(f)(1)(A)(ii) of this title where such services were initiated during the veteran's hospitalization and the provision of such services on an outpatient basis is essential to permit the discharge of the veteran from the hospital,

for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, travel and incidental expenses of such family member or individual in the case of a veteran who is receiving care for a service-connected disability, or in the case of a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title); and

"(ii) in the case of individuals who were recipients of services under subclause (i) of this clause at the time of the death of the veteran, such counseling services, for a period not to exceed six months, as the Administrator determines to be reasonable and necessary to assist such individuals with the emotional and psychological stress accompanying the veteran's death.

For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title shall be eligible for the same medical services as a veteran.".

### ELIGIBILITY FOR DOMICILIARY CARE

SEC. 5. (a) Subsection (b) of section 610 is amended to read as follows:

"(b) The Administrator, through Veterans' Administration facilities, may furnish such domiciliary care as the Administrator determines is needed by a veteran for the purpose of receiving treatment or rehabilitation if the Administrator finds, pursuant to regulations which the Administrator shall prescribe, that the veteran—

(1) has a service-connected disability, or

(2) is incapacitated from earning a living and has no adequate means of support.".

(b) Section 622(g) is amended by striking out "sections 610(b)(2) and" and inserting in lieu thereof "section".

EXTENSION OF ELIGIBILITY FOR READJUSTMENT COUNSELING AND RELATED MENTAL HEALTH SERVICES

SEC. 6. Subsection (a) of section 612A is amended—

(1) by inserting "(1)" before "Upon", and

(2) adding at the end the following new paragraph:

"(2)(A) Upon the request of—

"(i) a person who is serving on active duty and who also served on active duty during the Vietnam era, or

"(ii) a person (I) who is a veteran or is serving on active duty, and (II) who served on active duty after May 7, 1975, in an area during a period in which hostilities (as defined in subparagraph (B) of this subsection) occurred in such area,

the Administrator shall, within the limits of Veterans' Administration facilities, furnish counseling to assist such person in readjusting to civilian life or to active duty following service during such era or in such area.

"(B) For the purpose of subparagraph (A)(ii) of this subsection, the term 'hostilities' means a situation in which members of the Armed Forces were, as determined by the

Administrator in consultation with the Secretary of Defense, subjected to danger from armed conflict comparable to the danger to which members of the Armed Forces have been subjected in battle with the enemy during a period of war.".

### RESPITE CARE PILOT PROGRAM

SEC. 7. (a)(1) Subchapter II of chapter 17 is amended by adding at the end the following new section:

**"§ 620B. Respite care; pilot program**

"(a) During the period beginning on October 1, 1986, and ending on September 30, 1989, the Administrator may conduct a pilot program to furnish respite care services, as defined in subsection (b) of this section, and to evaluate the furnishing of such services, to any veteran who has a service-connected disability which is compensable in degree and who is receiving services under this chapter.

"(b) For the purposes of this section, the term "respite care" means hospital or nursing home care which (1) is of limited duration, (2) is furnished in a Veterans' Administration facility on an intermittent basis to a veteran who is suffering from a chronic illness and who resides primarily at home, (3) is furnished for the purpose of helping the veteran to continue residing primarily at home, and (4) does not (as determined by the head of the facility furnishing the care) adversely affect the range of services, the quality of care, or the established priorities for care furnished to other veterans seeking care at such facility."

(2) The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 620A the following new item:

"620B. Respite care; pilot program.".

(b) If the Administrator of Veterans' Affairs furnishes respite care under section 620B of title 38, United States Code (as added by subsection (a))—

(1) the Administrator shall conduct a study of the medical efficacy and cost-effectiveness of furnishing such care; and

(2) not later than February 1, 1990, submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing—

(A) the results of any such study;

(B) the Administrator's recommendation with respect to extending or repealing the date of September 30, 1989, in subsection (a) of section 620B of title 38, United States Code (as added by subsection (a)); and

(C) any other recommendation that the Administrator considers appropriate for legislative and administrative action with respect to the furnishing of such care.

## PILOT PROGRAM OF NONINSTITUTIONAL ALTERNATIVES TO INSTITUTIONAL CARE

SEC. 8. (a) Subchapter II of chapter 17 if further amended by adding at the end the following new section:

"SEC. 620C. Noninstitutional alternatives to institutional care; pilot program

"(a)(1) In order to evaluate the effectiveness, feasibility, and desirability of various actions that would obviate the need for furnishing hospital, nursing home, or domiciliary care to veterans eligible under this chapter for and otherwise in need of such care, the Administration, during the period beginning January 1, 1987, and ending December 31, 1990, and subject to subsection (c) of this section, shall conduct a pilot program under which such veterans will be furnished at ten demonstration project sites medical, rehabilitative, and health-related services in noninstitutional settings. Not less than five of such projects shall involve the use of a geriatric evaluation unit at a Veterans' Administration health-care facility.

"(2) In selecting veterans for participation in the program, the Administrator shall accord priority to veterans who have service-connected disabilities, to veterans who are 65 years of age or older, and to veterans who are totally and permanently disabled.

"(b)(1)(A) In order to avoid duplication of services available from the Veterans' Administration and other sources to veterans participating in the pilot program and to avoid fragmentation of effort under the program, the Administrator shall in the conduct of the program (i) furnish appropriate health-related services solely through contracts with appropriate public and private agencies that provide such services, and (ii) in the case of each veteran furnished services under the program, appoint a Veterans' Administration employee to furnish case management services.

"(B) For the purposes of subparagraph (A) of this paragraph, 'case management' includes the coordination and facilitation of all services furnished to a veteran by the Veterans' Administration, either directly or through a contract, including, but not limited to, screening, assessment of needs, planning, referral (including referral for services to be furnished by the Veterans' Administration, either directly or through a contract, or by an entity other than the Veterans' Administration), monitoring, reassessment, and follow up.

"(2) In order further to avoid such duplication and fragmentation and in order to evaluate the cost-effectiveness of utilizing certain health services of agencies other than the Veterans' Administration in cases in which no Veterans' Administration facility in the vicinity of a demonstration project provides such services, the Administrator, in not more than two of the projects, may utilize appropriate health services of appropriate public and private agencies that furnish such services.

"(3) The Administrator may provide in-kind assistance (through the services of Veterans' Administration employees and the sharing of other Veterans' Administration resources) to a facility furnishing services to veterans under paragraph (1)(A) of this subsection. Any such in-kind assistance shall be provided under a contract between the Veterans' Administration and the facility concerned. The Administrator may provide such assistance only for use solely in the furnishing of appropriate services under this section and only if, under such contract, the Veterans' Administration receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds alloted to the Veterans' Administration facility that provided the assistance.

"(c)(1) The total cost of conducting the pilot program under this section shall not exceed 60 percent of the cost that would have been incurred by the Veterans' Administration during the period of the pilot program if the veterans being furnished services under the pilot program had been furnished, instead, nursing home care under section 610 of this title. In any one fiscal year, the cost of carrying out the pilot program shall not exceed 65 per centum of the cost that would have been so incurred for such year under such section 610.

"(2) Expenditures for services furnished to veterans under the pilot program shall be made from appropriated funds that would otherwise have been expended to provide intermediate hospital care to eligible veterans.

"(d)(1) The Administrator shall conduct a study of the pilot program to determine with respect to the participating veterans—

"(A) the feasibility, medical advantages, and cost-effectiveness of the services furnished under the program as an alternative to hospital, nursing home, or domiciliary care; and

"(B) the extent to which such a program can—

"(i) furnish such veterans with more appropriate kinds and levels of care than they would otherwise receive;

"(ii) reduce hospital, nursing home, or domiciliary facility admission rates for such veterans;

"(iii) reduce the number of days that such veterans are institutionalized;

"(iv) reduce mortality rates among such veterans; and

"(v) reduce the cost of long-term care for such veterans under this chapter.

"(2) Not later than February 1, 1990, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives an interim report on the study required by paragraph (1) of this subsection setting forth the Administrator's findings based on the experience under the program for its first thirty-six months. The report shall include a description of the administration of the program (including a description of the veterans furnished services and of the services furnished under the pilot program), the Administrator's interim evaluation of and findings on the program (including the matters referred to in paragraph (1) of this subsection), and any recommendations for administrative or legislative action that the Administrator considers appropriate to include in the report.

"(3) Not later than April 1, 1991, the Administrator shall submit to such committees a final report on the study required by paragraph (1) of this subsection. The report shall include updates of all information provided in the interim report submitted pursuant to paragraph (2) of this subsection, the Administrator's final evaluation, findings, and conclusions regarding the program based on forty-eight months of operation (in the context of an assessment, which the report shall contain, of the needs of older eligible veterans for noninstitutional health and health-related services and of the availability of such services from non-Veterans' Administration sources), and any recommendations for administrative or legislative action that the Administrator considers appropriate to include in the report.".

(b) The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 620B (as added by section 7 of this Act) the following new item:

"620C. Noninstitutional alternatives to institutional care; pilot program.".

## RULES AND REGULATIONS RELATING TO HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

SEC. 9. Section 621 is revised to read as follows:

"The Administrator shall prescribe all rules and regulations which are necessary and appropriate to govern the furnishing of hospital, nursing home, and domiciliary care and medical services under laws administered by the Veterans' Administration and which are consistent therewith, including such rules and regulations as are necessary and appropriate in order to promote good conduct on the part of persons who are receiving such care or services in Veterans' Administration facilities.".

## MEDICAL CARE FOR VETERANS IN THE REPUBLIC OF THE PHILIPPINES

SEC. 10. Section 632 is amended—

(1) in subsection (a) by striking out "September 30, 1986" and inserting in lieu thereof "September 30, 1989"; and

(2) in subsection (b)(1) by striking out "September 30, 1986" and inserting in lieu thereof "September 30, 1989".

## INDEPENDENT LIVING SERVICES FOR SERVICE-CONNECTED DISABLED VETERANS

SEC. 11. Section 1520 is amended—

(1) by striking out subsection (b);

(2) by amending subsection (a)—

(A) in paragraph (1)—

(i) by striking out "During fiscal years 1982 through 1985, the" and inserting in lieu thereof "The"; and

(ii) by striking out after "chapter" the comma and "in various geographic regions of the United States,";

(B) by striking out paragraph (5) and redesignating paragraph (6) as subsection (b); and

(3) by amending subsection (b) as so redesignated by striking out "each of the fiscal years 1982 through 1985" and inserting in lieu thereof "any fiscal year".

AUTHORIZATION OF APPROPRIATIONS FOR GRANTS TO STATE VETERANS' HOMES

SEC. 12. Section 5033 is amended by striking out "five" and inserting in lieu thereof "ten".

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Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUL 1 1986

Honorable Frank H. Murkowski
Chairman, Committee on Veterans'
Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 2388, a bill "To amend title 38, United States Code, to improve various aspects of Veterans' Administration health-care programs, to provide eligibility to new categories of persons for readjustment counseling from the Veterans' Administration, to authorize the Administrator of Veterans' Affairs to establish programs for the furnishing of respite care to certain chronically ill service-connected disabled veterans and of noninstitutional care to certain veterans, to extend certain expiring authorities, and for other purposes."

S. 2388 contains several provisions favored by the VA, specifically amendments to the law which would authorize VA police to enforce traffic laws on VA property, clarify domiciliary care eligibility, authorize a respite care pilot program, and extend, respectively, VA's authority to furnish care in the Philippines, and VA's authority to make grants for State homes. Other major provisions of the bill would authorize VA to provide bereavement counseling, authorize VA to provide services to overcome infertility, mandate that VA conduct a pilot program to furnish veterans with primarily nonmedical support services as an alternative to institutional care, and permanently authorize the independent living services program. Detailed comments follow.

Section 2 of the bill would amend section 218 of title 38 to authorize Veterans Administration police officers to enforce State and local traffic laws for acts occurring on Veterans Administration property. This provision is identical to an administration proposal which was transmitted to the Committee on March 10, 1986.

Current law authorizes VA police officers to enforce only Federal laws and regulations promulgated by the Administrator. Because of the general unwillingness of United States District Court judges to themselves hear violations of agency regulations, such violations may be prosecuted only in the local districts where District Courts have entered orders or published rules permitting us to refer violations of these regulations occurring on VA property to U.S. Magistrates for disposition. While most district courts have entered such rules, not all have done so. Under these circumstances, authority for effective security and traffic control at some VA facilities remains seriously deficient. This measure would provide authority for the VA, with the cooperation of State and local authorities, to correct those situations where VA police officers lack authority to control automobile traffic and parking on VA property. Such authority would improve the VA's ability to control automobile parking and traffic on VA grounds by the issuance of citations under State and local codes and the prosecution of those violations in State and local traffic courts. We strongly support this measure.

We estimate the costs of enactment of section 2 would be insignificant.

Section 3 of the bill would authorize VA to furnish services to achieve pregnancy in a veteran, or a veteran's spouse, if necessary to overcome a service-connected disability which impairs the veteran's procreative ability. We note that the Office of Technology Assessment is embarked on a detailed analysis of this subject. Considerably more research and inquiry is necessary in this field; therefore, we recommend against this provision.

We estimate that the costs of section 3 would be $.4 million in the first fiscal year and $3.5 million over five fiscal years.

Section 4 of the bill would amend title 38 to authorize VA to provide a period of bereavement counseling to family members who were receiving VA counseling services in connection with treatment of the veteran at the time of death. Such services could be authorized for up to six months under this provision. We recommend modification of this measure to limit the provision of bereavement counseling to services furnished in a hospice setting. With such a revision, we would favor section 4. We project that the enactment of such a provision would not impose significant additional costs.

We estimate that the costs of section 4 would be $.1 million in the first fiscal year, and $.5 million over five fiscal years.

Section 5 of the bill would amend title 38 to change and clarify the eligibility criteria for domiciliary care. It would provide that to be eligible for domiciliary care, a veteran must need such care and be either (1) service-connected, or (2) be incapacitated from earning a living and have no adequate means of support.

Under existing domiciliary care eligibility provisions the law appears to impose more stringent requirements on the service-connected veteran than on other veterans. Thus, to be eligible for domiciliary care, the service-connected veteran must have a permanent disability, tuberculosis, or a neuropsychiatric ailment; be incapacitated from earning a living; and have no adequate means of support. In contrast, statutory provisions governing domiciliary eligibility for other veterans impose none of these requirements, and condition eligibility on an "inability to defray" and a need for such care. We believe the proposed change in eligibility rectifies this inequity. We favor its enactment.

We estimate that enactment of section 5 would not impose additional costs.

Section 6 of the bill would authorize the VA to provide readjustment counseling to (1) persons still on active duty with the Armed Services who served during the Vietnam era, and (2) to those who served in the Armed Services after the Vietnam era in combat situations. We believe our readjustment counseling program has been an effective one, and one which could benefit active duty personnel who served in Vietnam as well as in combat areas such as Grenada and Lebanon. In that connection, we would support an amendment to section 612A to extend eligibility for such services to those veterans who served on active duty during a period after May 7, 1975, in an area in which hostilities occurred. We see no need, however, for extending such eligibility to active duty members.

We estimate that section 6 would impose insignificant costs.

Section 7 of the bill would authorize establishment of a three-year pilot program under which VA may furnish respite care to certain compensably rated service-connected veterans. The measure would authorize the provision of VA hospital or nursing home care of limited duration, on an intermittent basis for the purpose of helping the veteran to continue to reside primarily at home. This provision is very similar to an Administration proposal which was transmitted to the Committee in the first session of the 99th Congress.

Currently VA lacks clear statutory authority to furnish care in VA health facilities on a prearranged basis to chronically ill veterans in order to provide brief periods of respite to care givers in the veterans' household. The clinical objective of providing institutionally based respite care is to support the care giver's role in caring for a chronically ill patient at home. The patient may also benefit directly by virtue of treatment received in the institution. The critical element of respite arrangements is that the respite is planned in advance for the benefit of the care giver, rather than being incidental to the provision of necessary medical care of the patient.

It is generally recognized that most chronically ill persons who do not need hospital services can be most effectively, most economically, and overall most satisfactorily cared for if, through the assistance of family or other members of the household, they are able to live at home. At the same time, there is genuine recognition that such arrangements for care of a patient at home place severe physical and emotional burdens on the care givers and the household generally. These difficulties often become exacerbated during the course of illness, particularly if there is no break in the continuum of the patient's care.

This provision would authorize VA to provide respite care to patients to whom we owe the highest priority. It would also provide a basis for our evaluating the efficacy of the respite care concept in avoiding or delaying the need for prolonged institutionalization, and, therefore, its potential for cost-savings. Accordingly, we strongly support this provision.

We estimate that section 7 would be implemented within existing resources.

Section 8 of the bill would require VA to conduct a 4-year pilot program at ten geographic sites through which participating veterans would receive appropriate health and health-related services such as homemaker, personal care, and transportation services. VA would be required to furnish appropriate "health-related" services solely by contract with appropriate public and private agencies, as well as to provide "case management" services (as defined) to each participant. The measure sets additional requirements as to the program's design, and requires VA to evaluate the effectiveness of providing alternative modes of care, as well as to assess the impact of that effort.

VA favors the basic concept of developing alternatives to institutional care, and, accordingly, we operate programs such as adult day health care and hospital based home care as alternatives to institutional care and have sought authority such as proposed in section 7 of this bill to operate a respite care pilot program. We do not favor the particular program that is proposed, however. Although the pilot program might provide VA with the means to evaluate the benefits of providing new health-related services, the provision is unduly prescriptive in directing the scope and operation of the pilot program. We object to the fact that this provision would mandate the conduct of this program.

Moreover, we see no need for Congress to mandate the design of such an effort, such as in setting in law specific minimum numbers of geographic areas, the use of specific numbers of VA geriatric evaluation units, and the degree to which VA must contract for services. In many respects, the requirements of the measure are so specific that they deprive VA of the latitude needed to derive real benefits from any such pilot program.

We estimate the costs of section 8 to be $9.2 million in the first fiscal year and $49.2 million over five fiscal years.

Section 9 of the bill would amend section 621 of title 38, which directs the Administrator to promulgate rules and regulations which are necessary and appropriate for the efficient provision of VA health care. The statute refers only to hospital, nursing home, and domiciliary care, all inpatient care programs, but does not refer to medical services, which include outpatient care. We agree that it is appropriate to add references to "medical services," as this provision does, making the section applicable to care furnished on an outpatient basis. We see no reason, however, to delete the long-standing provision currently set forth in section 621(2), and we oppose that aspect of the provision.

We estimate that enactment of section 9 would not impose additional costs.

Section 10 of the bill would extend the VA's authority to provide payment for care to U.S. veterans in the Philippines in the Veterans Memorial Medical Center (VMMC) and to make grants of up to $500,000 annually to the VMMC for replacing and upgrading equipment and rehabilitating its physical plant and facilities. Before and during the Second World War, thousands of Filipinos served in or with the United States Armed Forces in the Philippines. Many of these veterans were casualties of that War. This Country has consistently reaffirmed its moral obligation to provide medical care and treatment for these veterans.

In 1948, Congress authorized a five-year grant program to provide medical benefits to Filipino veterans, including the construction and equipping of a hospital in Luzon. That hospital, which is now the Veterans Memorial Medical Center, was turned over to the Philippine Government in 1955. However, Congress provided and regularly extended authority to VA to provide care to United States veterans in the VMMC and grants to that facility to continue the high standard of medical care to United States veterans.

Although we believe that it has always been the clear intent of Congress that the Philippine Government should take full responsibility for the VMMC, we believe that the authority to provide grants to the VMMC, as well as authority to provide contract care to U.S. veterans in that facility should be continued. To terminate these grants now could jeopardize the operation of the VMMC and its ability to satisfactorily maintain its complex and replace and update essential medical equipment and supplies. Because of the need for VA assistance for these veterans, we also recommend that the authorities to provide contract care and grants be extended for an additional five years, through September 30, 1991, instead of three more years, as proposed in this measure.

We estimate the costs of section 10 to be $.5 million in the first fiscal year and $1.5 million over five fiscal years.

Section 11 of the bill would amend the provisions of the chapter 31 pilot program of independent living services (38 U.S.C. § 1520). The amendments would make the program a permanent part of the benefits and services provided under chapter 31; remove the limitation that the program be conducted in various geographic regions of the United States; and eliminate the report to Congress required by the original provisions of law.

Based upon initial study data concerning implementation of this pilot program, the VA determined that the pilot program of independent living services and assistance produced favorable results for some of the veterans who availed themselves of services. However, the data base for the study was too small to draw definitive conclusions concerning effectiveness of the program. Additional data over a longer period would provide a better evaluation of the outcomes of the program. Therefore, in a report entitled "Supplemental Report of the Program of Independent Living Services and Assistance, Section 1520(b), title 38, United States Code," submitted to Congress on August 26, 1985, the VA proposed that the program of independent living services be continued as a pilot project for a period of 3 additional years. Accordingly, we would oppose enactment of the provisions of this section, but would urge favorable consideration be given to the proposed pilot program extension we have recommended.

We estimate that enactment of section 11 would not impose significant new costs.

Section 12 of the bill would extend, for three years, VA's authority to provide grants to States for the construction or acquisition of State home facilities for furnishing domiciliary and nursing home care, and for remodeling or renovation of State home facilities for furnishing hospital, domiciliary and nursing home care. This authority will expire at the end of this fiscal year. VA strongly supports an extension of this program.

This important cost-sharing program makes it possible to extend medical care to veterans beyond that which can be provided in VA facilities. It is a cost-effective approach, with Federal participation limited to no more than 65 percent of the cost of any one project and a minimal per diem payment to help defray state home operating costs.

8.

Honorable Frank H. Murkowski

There are now State homes in 35 States. Nursing home care is provided in 45 homes, domiciliary care in 43 homes, and hospital care in seven homes. From Fiscal Year 1966 through Fiscal Year 1985, approximately $179 million was obligated in support of new nursing home care and domiciliary beds and for remodeling and modifying existing buildings. Eighty-three percent of the funds have been used for bed-producing projects. The remainder has been used for remodeling and renovation. The estimated cost of extending this authority for Fiscal Year 1987 would be $42.4 million and $42 million for each of the subsequent years. Because of the importance and effectiveness of this program, we favor extending this authority for an additional five years instead of three years, as proposed in the bill.

In this connection we also recommend that you eliminate the limitation in law which provides that no one State may receive in any fiscal year more than one-third of the amount appropriated in that fiscal year for grants to assist States in the acquisition or construction of State veterans' homes. This limitation was enacted to prevent perceived abuses in the grant program. At the time, it was believed that few States had received inequitably large grants. This limitation has not, however, prevented the approval of any State home grant request. Because Congress typically permits funds appropriated for State home construction grants to remain available for three fiscal years, a large grant can be funded from more than one fiscal year's appropriation. We proposed repeal of this provision as part of our legislative program because the only effect of this limitation is to delay approval of large State home grant applications until enough money to fund the grant can be accumulated from different fiscal years' appropriations.

We estimate the costs of section 12 to be $42.0 million in the first fiscal year, and $210.0 million over five fiscal years. We estimate the total costs of this bill to be $52.2 million for Fiscal Year 1987 and $264.7 million for the first five fiscal years.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administrations' program.

Sincerely,

THOMAS K. TURNAGE
Administrator

II

99TH CONGRESS
2D SESSION

# S. 2422

To amend title 38, United States Code, to increase the rates of disability compensation for disabled veterans and the rates of dependency and indemnity compensation for surviving spouses and children of veterans; to improve the Veterans' Administration home loan guaranty program; to authorize certain debt collections; to authorize the Administrator of Veterans' Affairs to require additional information from certain fiduciary agents of veterans; to revise the authority of the Administrator of Veterans' Affairs to construct, alter, acquire, operate, and maintain parking facilities at Veterans' Administration medical facilities; and to authorize an administrative reorganization in the Veterans' Administration.

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## IN THE SENATE OF THE UNITED STATES

MAY 8 (legislative day, MAY 5), 1986

Mr. MURKOWSKI (for himself, Mr. CRANSTON, and Mr. THURMOND) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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# A BILL

To amend title 38, United States Code, to increase the rates of disability compensation for disabled veterans and the rates of dependency and indemnity compensation for surviving spouses and children of veterans; to improve the Veterans' Administration home loan guaranty program; to authorize certain debt collections; to authorize the Administrator of Veterans' Affairs to require additional information from certain fiduciary agents of veterans; to revise the authority of the Administrator of Veterans' Affairs to construct, alter, acquire, operate, and maintain parking facilities at Veterans' Administration medical facilities; and to authorize an administrative reorganization in the Veterans' Administration.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

### SECTION 1. SHORT TITLE AND REFERENCES

(a) SHORT TITLE.—This Act may be cited as the "Veterans' Compensation and Benefits Improvements Act of 1986".

(b) REFERENCES.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

## TITLE I—DISABILITY COMPENSATION AND DEPENDENCY AND INDEMNITY COMPENSATION RATE INCREASES

### SEC. 101. DISABILITY COMPENSATION

(a) IN GENERAL.—Section 314 is amended—

(1) by striking out "$68" in subsection (a) and inserting in lieu thereof "$70";

(2) by striking out "$126" in subsection (b) and inserting in lieu thereof "$130";

(3) by striking out "$191" in subsection (c) and inserting in lieu thereof "$197";

(4) by striking out "$274" in subsection (d) and inserting in lieu thereof "$283";

(5) by striking out "$388" in subsection (e) and inserting in lieu thereof "$401";

(6) by striking out "$489" in subsection (f) and inserting in lieu thereof "$506";

(7) by striking out "$617" in subsection (g) and inserting in lieu thereof "$638";

(8) by striking out "$713" in subsection (h) and inserting in lieu thereof "$737";

(9) by striking out "$803" in subsection (i) and inserting in lieu thereof "$830";

(10) by striking out "$1,335" in subsection (j) and inserting in lieu thereof "$1,380";

(11) by striking out "$1,659" and "$2,325" in subsection (k) and inserting in lieu thereof "$1,715" and "$2,404", respectively;

(12) by striking out "$1,659" in subsection (l) and inserting in lieu thereof "$1,715";

(13) by striking out "$1,829" in subsection (m) and inserting in lieu thereof "$1,891";

(14) by striking out "$2,080" in subsection (n) and inserting in lieu thereof "$2,151";

(15) by striking out "$2,325" each place it appears in subsections (o) and (p) and inserting in lieu thereof "$2,404";

(16) by striking out "$998" and "$1,487" in subsection (r) and inserting in lieu thereof "$1,032" and "$1,538", respectively;

(17) by striking out "$1,494" in subsection (s) and inserting in lieu thereof "$1,545"; and

(18) by striking out "$289" in subsection (t) and inserting in lieu thereof "$299".

(b) SPECIAL RULE.—The Administrator of Veterans' Affairs may adjust administratively, consistent with the increases authorized by this section, the rates of disability compensation payable to persons within the purview of section 10 of Public Law 85-857 who are not in receipt of compensation payable pursuant to chapter 11 of title 38, United States Code.

### SEC. 102. ADDITIONAL COMPENSATION FOR DEPENDENTS

Section 315(1) is amended—

(1) by striking out "$81" in clause (A) and inserting in lieu thereof "$84";

(2) by striking out "$136" and "$43" in clause (B) and inserting in lieu thereof "$141" and "$44", respectively;

(3) by striking out "$56" and "$43" in clause (C) and inserting in lieu thereof "$58" and "$44", respectively;

(4) by striking out "$66" in clause (D) and insert-

ing in lieu thereof “$68”;

(5) by striking out “$147” in clause (E) and inserting in lieu thereof “$152”; and

(6) by striking out “$124” in clause (F) and inserting in lieu thereof “$128”.

## SEC. 103. CLOTHING ALLOWANCE FOR CERTAIN DISABLED VETERANS

Section 362 is amended by striking out “$360” and inserting in lieu thereof “$372”.

## SEC. 104. DEPENDENCY AND INDEMNITY COMPENSATION FOR SURVIVING SPOUSES

Section 411 is amended—

(1) by striking out the table in subsection (a) and inserting in lieu thereof the following:

| “Pay grade | Monthly rate | Pay grade | Monthly rate |
|---|---|---|---|
| E-1 | $508 | W-4 | $727 |
| E-2 | 522 | O-1 | 642 |
| E-3 | 536 | O-2 | 662 |
| E-4 | 571 | O-3 | 709 |
| E-5 | 585 | O-4 | 750 |
| E-6 | 598 | O-5 | 826 |
| E-7 | 628 | O-6 | 931 |
| E-8 | 662 | O-7 | 1,006 |
| E-9 | [1] 692 | O-8 | 1,103 |
| W-1 | 642 | O-9 | 1,184 |
| W-2 | 667 | O-10 | [2] 1,298 |
| W-3 | 687 | | |

“[1] If the veteran served as sergeant major of the Army, senior enlisted advisor of the Navy, chief master sergeant of the Air Force, sergeant major of the Marine Corps, or master chief petty officer of the Coast Guard, at the applicable time designated by section 402 of this title, the surviving spouse’s rate shall be $747.

“[2] If the veteran served as Chairman of the Joint Chiefs of Staff, Chief of Staff of the Army, Chief of Naval Operations, Chief of Staff of the Air Force, Commandant of the Marine Corps, or Commandant of the Coast Guard, at the applicable time designated by section 402 of this title, the surviving spouse’s rate shall be $1,391.”;

(2) by striking out "$57" in subsection (b) and inserting in lieu thereof "$59";

(3) by striking out "$147" in subsection (c) and inserting in lieu thereof "$152"; and

(4) by striking out "$72" in subsection (d) and inserting in lieu thereof "$74".

### SEC 105. DEPENDENCY AND INDEMNITY COMPENSATION FOR CHILDREN

Section 413 is amended—

(1) by striking out "$247" in clause (1) and inserting in lieu thereof "$255";

(2) by striking out "$356" in clause (2) and inserting in lieu thereof "$368";

(3) by striking out "$460" in clause (3) and inserting in lieu thereof "$476"; and

(4) by striking out "$460" and "$93" in clause (4) and inserting in lieu thereof "$476" and "$96", respectively.

### SEC. 106. SUPPLEMENTAL DEPENDENCY AND INDEMNITY COMPENSATION FOR CHILDREN

Section 414 is amended—

(1) by striking out "$147" in subsection (a) and inserting in lieu thereof "$152";

(2) by striking out "$247" in subsection (b) and inserting in lieu thereof "$255"; and

(3) by striking out "$126" in subsection (c) and inserting in lieu thereof "$130".

### SEC. 107. EFFECTIVE DATE

Except as provided in section 108 of this Act, the amendments made by sections 101 through 106 of this Act shall take effect on December 1, 1986.

### SEC. 108. ALTERNATIVE RATE INCREASES

(a) IN GENERAL.—(1) If the percentage of the increase in benefit amounts under title II of the Social Security Act that will take effect on December 1, 1986, as a result of a determination under section 215(i) of such Act or as a result of any other law is not 3.4 percent—

(A) sections 101 through 106 of this Act shall not take effect; and

(B) the Administrator of Veterans' Affairs shall (i) compute alternative increased rates and limitations that are equal to those that would be arrived at by increasing, by the same percentage as the percentage by which such benefit amounts will thus be increased, each dollar amount that would have been increased by the amendments that would have been made by such sections, and (ii) effective December 1, 1986, pay benefits under chapters 11 and 13 of title 38, United States Code, in accordance with such alternative increased rates and limitations.

(2) In the computation of alternative increased rates and limitations pursuant to paragraph (1)(B), amounts of $0.50 or more shall be rounded to the next higher dollar amount and amounts of less than $0.50 shall be rounded to the next lower dollar amount.

(b) SPECIAL RULE.—The Administrator may adjust administratively, consistent with the increases authorized by this section, the rates of disability compensation payable to persons within the purview of section 10 of Public Law 85-857 who are not in receipt of compensation payable pursuant to chapter 11 of title 38, United States Code.

(c) PUBLICATION REQUIREMENT.—If, under subsection (a) of this section, the Administrator is required to compute alternative increased rates and limitations, the Administrator shall publish in the Federal Register such alternative increased rates and limitations and the rates and limitations being increased. The Administrator shall publish such matters at the same time as the matters required by section 215(i)(2)(D) of the Social Security Act (42 U.S.C. 415(i)(2)(D)) are published by reason of a determination under section 215(i) of such Act.

## TITLE II—IMPROVEMENT IN THE ADMINISTRATION OF THE VETERANS' HOME LOAN GUARANTY PROGRAM

### SEC. 201. VETERANS' ADMINISTRATION ACQUISITION OF FORECLOSED PROPERTY

Section 1816(c) is amended—

(1) by striking out "In" in paragraph (5) and inserting in lieu thereof "Except as provided in paragraph (10) of this subsection, in";

(2) by striking out "In" in paragraph (7) and inserting in lieu thereof "Except as provided in paragraph (10) of this subsection, in"; and

(3) by adding at the end thereof the following new paragraph:

"(10)(A) The holder of a defaulted loan shall not have the option of conveying the property securing the loan to the United States under paragraph (5) of this subsection and the Administrator may not except conveyance of such property under paragraph (7) of this subsection unless the Administrator determines, on the basis of the considerations prescribed in subparagraph (B) of this paragraph, that the Administrator is likely to be able, within one year after the date of the liquidation sale of the property, to sell the property for a price which would make it economically advantageous to the

United States for the Administrator to acquire and dispose of the property.

"(B) In making a determination with respect to a particular property for the purpose of subparagraph (A) of this paragraph, the Administrator shall consider—

"(i) the size of the inventory of properties held by the Veterans' Administration (after acquisition under this section) which are located in the same general real estate market area as such property;

"(ii) the current and projected conditions of the real estate market in such area; and

"(iii) the current and projected general economic conditions in such area.".

## TITLE III—IMPROVEMENTS IN OTHER VETERANS' PROGRAMS

### SEC. 301. ADMINISTRATIVE DEBT COLLECTION BY OFFSET OF BENEFITS

Section 3101 is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following new subsection (c):

"(c)(1) Notwithstanding any other provision of this section, the Administrator may, after receiving a request under paragraph (2) of this subsection relating to a veteran, collect by offset of any compensation or pension payable to the veteran under laws administered by the Veterans' Administration the uncollected portion of (A) the amount of any overpayments of retired or retainer pay (for service in a uniformed service named in section 101(3) of title 37) made to the veteran, and (B) the amount of any indebtedness associated with the veteran's participation in a plan prescribed in subchapter I or II of chapter 73 of title 10.

"(2) If the Secretary concerned (as defined in section 101(5) of title 37) has tried under section 3711(a) of title 31 to collect an amount described in paragraph (1) of this subsection in the case of any veteran, has been unable to collect such amount, and has determined that the uncollected portion of such amount is not collectible from amounts payable by the Secretary to the veteran or that the veteran is not receiving any payment from the Secretary, the Secretary may request the Administrator to make collections in the case of such veteran as authorized in paragraph (1) of this subsection.

"(3)(A) A collection authorized by paragraph (1) of this subsection shall be conducted in accordance with the procedures prescribed in section 3716 of title 31 for administrative offset collections made after attempts to collect claims under section 3711(a) of such title.

"(B) For the purpose of subparagraph (A) of this paragraph, as used in the second sentence of section 3716(a) of title 31—

"(i) the term 'records of the agency' shall be considered to refer to the records of the department of the Secretary concerned; and

"(ii) the term 'agency' in clauses (3) and (4) shall be considered to refer to such department.".

## SEC. 302. DISCLOSURE OF FINANCIAL INFORMATION BY FEDERAL FIDUCIARIES

The second sentence of section 3202(b) is amended by striking out "beneficiary," and inserting in lieu thereof "beneficiary and any additional information about the beneficiary's financial circumstances required by the Administrator (unless unknown by the fiduciary),".

## SEC. 303. CONSTRUCTION, ALTERATION, AND ACQUISITION OF PARKING FACILITIES AT VETERANS' ADMINISTRATION MEDICAL FACILITIES

(a) In General.—Section 5009 of title 38, United States Code, is amended to read as follows:

**"§ 5009. Parking facilities**

"(a) For the purposes of this section—

"(1) the term 'garage' means a structure (or part of a structure) in which vehicles may be parked; and

"(2) the term 'parking facility' includes a surface parking lot and a garage.

"(b) In order to accommodate the vehicles of employees of medical facilities, vehicles used to transport veterans to or from such facilities for the purpose of examination or treatment, and the vehicles of visitors and other individuals having business at such facilities, the Administrator—

"(1) may construct or alter parking facilities on reservations of medical facilities, and may acquire, by purchase, lease, condemnation, donation, exchange, or otherwise, such land or interests in land as the Administrator considers necessary for use as the site for any such construction or alteration;

"(2) may acquire, by purchase, lease, condemnation, donation, exchange, or otherwise, any facility that the Administrator considers necessary for use as a parking facility (including the site for a parking facility); and

"(3) may operate and maintain parking facilities.

"(c)(1) Except as provided in paragraph (2) of this subsection, each employee, visitor, and other individual having business at a medical facility for which parking fees have been established under subsection (d) or (e) of this section shall be charged the applicable parking fee for the use of a parking facility at such medical facility.

"(2) A parking fee shall not be charged under this subsection for the accommodation of any vehicle used to transport a veteran to or from any medical facility for the purpose of examination or treatment.

"(3) The Administrator shall collect (or provide for the collection of) parking fees charged under this subsection.

"(d)(1) For each medical facility where—

"(A) a garage constructed or acquired at a cost exceeding $500,000 is first opened for use after September 30, 1986; or

"(B) a project for the alteration of a garage at a cost exceeding $500,000 is completed after September 30, 1986,

the Administrator shall prescribe a schedule of parking fees to be charged at all parking facilities used in connection with such medical facility.

"(2) The parking fee schedule prescribed for a medical center referred to in paragraph (1) of this subsection shall be designed to establish fees which the Administrator determines are reasonable under the circumstances and will provide sufficient revenues to recover the costs of operating and maintaining all parking facilities at such medical facility.

"(e) The Administrator may prescribe a schedule of parking fees for the parking facilities at any medical facility not referred to in subsection (d) of this section. Any such schedule shall be designed to establish fees which the Administrator determines to be reasonable under the circumstances. The Administrator may consider the costs of operating and maintaining such parking facilities in prescribing any such fee schedule.

"(f) The Administrator may contract, by lease or otherwise, with persons, firms, or corporations for the operation of parking facilities at medical facilities under such terms and conditions as the Administrator shall prescribe and without regard to laws requiring full and open competition.

"(g) Subject to subsections (h) and (i) of this section, there are authorized to be appropriated such amounts as are necessary to finance (in whole or in part)—

"(1) the construction, alteration, and acquisition (including site acquisition) of parking facilities; and

"(2) the operation and maintenance of parking facilities.

"(h)(1) Amounts appropriated pursuant to subsection (g) of this section and parking fees collected under subsection (c) of this section shall be administered as a revolving fund and shall be available without fiscal year limitation to carry out this section.

"(2)(A) Except as provided in subparagraph (B) of this paragraph, the revolving fund shall be deposited in a checking account with the Treasurer of the United States.

"(B) The Administrator may deposit in depositories selected by the Administrator such amounts as the Administrator determines necessary to establish and maintain accounts for the purposes of the operation and maintenance of parking facilities.

"(3) No funds other than funds from the revolving fund may be used for the construction, alteration, or acquisition (including site acquisition) of a parking facility at a medical facility after September 30, 1986.

"(i)(1) The expenditure of funds from the revolving fund for the construction, alteration, acquisition (including site acquisition), operation, and maintenance of parking facilities may be made only as provided for in appropriation Acts.

"(2) For the purpose of section 5004(a)(2) of this title, a bill, resolution, or amendment which provides that funds in the revolving fund (including any funds proposed in such bill, resolution, or amendment to be appropriated to the revolving fund) may be expended for a project involving a total expenditure of more than $2,000,000 for the construction, alteration, or acquisition (including site acquisition) of a parking facility or facilities at a medical facility shall be considered to be a bill, resolution, or amendment making an appropriation which may be expended for a major medical facility project.".

(b) CONFORMING AMENDMENT.—The table of sections at the beginning of chapter 81 of such title is amended by striking out the item relating to section 5009 and inserting in lieu thereof the following:

"5009. Parking facilities.".

### SEC. 304. WAIVER OF CONGRESSIONAL NOTICE AND WAITING PERIOD FOR ADMINISTRATIVE REORGANIZATION OF CERTAIN VETERANS' ADMINISTRATION ACTIVITIES

(a) WAIVER.—The Administrator of Veterans' Affairs may undertake the administrative reorganization described in subsection (b) without regard to the requirements of section 210(b)(2) of title 38, United States Code.

(b) COVERED ADMINISTRATIVE REORGANIZATION.—The administrative reorganization referred to in subsection (a) is a reorganization that—

(1) involves the transfer of certain functions from the Office of Administration of the Veterans' Administration to the Department of Veterans' Benefits and to the Office of the Associate Deputy Administrator of Veterans' Affairs for Public and Consumer Affairs; and

(2) is described in letters dated February 5, 1986, that were submitted by the acting Administrator of Veterans' Affairs to the President of the Senate and the Speaker of the House of Representatives.

○

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

AUG 1 5 1986

Honorable Frank H. Murkowski
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This is in reply to your request for our views on S. 2422, as introduced, and for our estimate of costs of the bill if enacted.

Our views on all of the provisions of this bill were detailed in testimony delivered by the Chief Medical and Benefits Directors before your Committee on May 20, 1986. (We refer you to pp. 26-37 of their prepared remarks, copy enclosed.) Brief restatements of our positions, and cost estimates, follow.

Title I (Compensation Rate Increases): The Veterans Administration (VA) strongly supports a cost-of-living increase for disability compensation, DIC, and associated benefits enumerated in title I of S. 2422 to help offset the erosion of purchasing power resulting from increases in consumer prices. VA's position is that the next COLA in these rates should occur at the same time, and be of the same percentage, as the next COLA in Social Security benefits. Cost estimate for Title I of S. 2422, which would authorize a 3.4% COLA effective December 1, 1986:

| Fiscal Year | Cost ($ millions) |
|---|---|
| 1987 | 289.0 |
| 1988 | 345.6 |
| 1989 | 344.8 |
| 1990 | 343.8 |
| 1991 | 342.7 |

Title II (Improvement of Home Loan Guaranty Program: The VA has no objections to the basic purpose of Title II, but we do have some technical suggestions which are outlined on page 33 of the enclosed testimony. Estimated costs: insignificant.

Title III (Improvement in Other Veterans' Programs):

Sec. 301: VA favors this provision to enable DoD to recover, by offset, certain retirement program and survivor plan debts from VA disability compensation and pension recipients. Estimated costs: insignificant.

Sec. 302: This is a VA proposal to authorize the Agency to require that fiduciaries for VA beneficiaries furnish information about the beneficiaries' non-VA income and assets. Estimated costs: insignificant.

Sec. 303: VA opposes this provision, which would impose mandatory parking fees on non-patients at certain VA medical centers, because we object to the bill's creation of a parking revolving fund, an unnecessary administrative burden. Five-year estimated costs:

| Fiscal Year | Cost ($ millions) |
|---|---|
| 1987 | 20.0 |
| 1988 | 22.1 |
| 1989 | 7.7 |
| 1990 | 7.0 |
| 1991 | 6.4 |

Sec. 304: VA requested enactment of this provision, which would waive the congressional waiting period, required by 38 U.S.C. § 210(b)(2), for purposes of a minor reorganization within VA Central Office. Specifically, the proposal involves our planned transfer of the Presidential Memorial Certificates Program and the Audio Visuals Service to the Office of the Associate Deputy Administrator for Public and Consumer Affairs. Estimated costs: None.

Advice has been received from the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

II

99TH CONGRESS
2D SESSION

# S. 2423

To amend title 38, United States Code, to provide for certain Veterans' Administration benefits which are paid based on the service-connected disability or death of a veteran to be paid in accordance with laws administered by the Veterans' Administration and to provide for certain Veterans' Administration insurance programs and revolving funds generally to be administered, and Veterans' Administration home loan guarantees for certain refinancing loans to be provided, in accordance with such laws.

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IN THE SENATE OF THE UNITED STATES

MAY 8 (legislative day, MAY 5), 1986

Mr. DECONCINI introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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# A BILL

To amend title 38, United States Code, to provide for certain Veterans' Administration benefits which are paid based on the service-connected disability or death of a veteran to be paid in accordance with laws administered by the Veterans' Administration and to provide for certain Veterans' Administration insurance programs and revolving funds generally to be administered, and Veterans' Administration home loan guarantees for certain refinancing loans to be provided, in accordance with such laws.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

### SECTION 1. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

### SEC. 2. BENEFITS BASED ON SERVICE-CONNECTED DISABILITY OR DEATH.

(a) BURIAL BENEFITS.—Section 907 is amended—

(1) by inserting "(a)" before "In"; and

(2) by adding at the end the following new subsection:

"(b) Benefits under this section shall be provided, except as otherwise provided by a law enacted in express limitation of this section, in accordance with this chapter and other laws administered by the Veterans' Administration and without regard to any law providing for the cancellation of authority to make payments.".

(b) SPECIALLY ADAPTED HOUSING AND MORTGAGE PROTECTION LIFE INSURANCE.—(1) Chapter 21 is amended by adding at the end the following new section:

**"§ 807. Law governing benefits**

"Benefits under this chapter shall be provided, except as otherwise provided by a law enacted in express limitation of this section, in accordance with this chapter and other laws administered by the Veterans' Administration and without regard to any law providing for the cancellation of authority to make payments.".

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

"807. Laws governing benefits.".

(c) REHABILITATION SERVICES AND ASSISTANCE.—(1) Chapter 31 is amended by adding at the end the following new section:

**"§ 1522. Laws governing benefits**

"Benefits under this chapter shall be provided, except as otherwise provided by a law enacted in express limitation of this section, in accordance with this chapter and other laws administered by the Veterans' Administration and without regard to any law providing for the cancellation of authority to make payments.".

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

"1522. Laws governing benefits.".

(d) SURVIVORS' AND DEPENDENTS' EDUCATIONAL ASSISTANCE.—(1) Subchapter VI of chapter 35 is amended by adding at the end the following new section:

**"§ 1764. Laws governing benefits**

"Benefits under this chapter shall be provided, except as otherwise provided by a law enacted in express limitation of this section, in accordance with this chapter and other laws administered by the Veterans' Administration and without regard to any law providing for the cancellation of authority to make payments.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1763 the following new item:

"1764. Laws governing benefits.".

(e) ADAPTED AUTOMOBILES AND ADAPTIVE AUTOMOBILE EQUIPMENT.—(1) Chapter 39 is amended by adding at the end the following new section:

**"§ 1905. Laws governing benefits**

"Benefits under this chapter shall be provided, except as otherwise provided by a law enacted in express limitation of this section, in accordance with this chapter and other laws administered by the Veterans' Administration and without regard to any law providing for the cancellation of authority to make payments.".

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

"1905. Laws governing benefits.".

(f) EXCLUSION OF CERTAIN BENEFITS FROM THE COMPUTATION OF REDUCTIONS IN BUDGET ACCOUNTS.—In the computation of the amount by which any budget account from which the payment of a benefit under section 907 or chapter 21, 31, 35, or 39 of title 38, United States Code, must be reduced during a fiscal year pursuant to a law providing for the cancellation of authority to make payments, the amount included in such account for the payment of such benefit during such fiscal year shall be excluded.

**SEC. 3. VETERANS' INSURANCE POLICY LOANS.**

(a) Subchapter IV of chapter 19 is amended by adding at the end the following new section:

**"§ 789. Laws governing making of loans**

"Loans under any insurance program administered by the Administrator shall be made, except as otherwise provided by a law enacted in express limitation of this section, in accordance with this chapter and other laws administered by the Veterans' Administration and without regard to any law providing for the cancellation of authority to make direct loan obligations.".

(b) The table of sections at the beginning of such chapter is amended by adding at the end the following new item:

"789. Laws governing making of loans.".

**SEC. 4. REVOLVING FUNDS.**

(a) SPECIAL THERAPEUTIC AND REHABILITATION ACTIVITIES FUND.—(1) Section 618(c) is amended by inserting at the end the following new paragraph:

"(4) Moneys in the fund shall be paid, except as otherwise provided by a law enacted in express limitation of this paragraph, in accordance with this section and other laws administered by the Veterans' Administration and without regard to any law providing for the cancellation of authority to make payments.".

(b) CANTEEN SERVICE REVOLVING FUND.—Section 4205 is amended—

(1) by inserting "(a)" before "The"; and

(2) by adding at the end the following new subsection:

"(b) Moneys in the revolving fund shall be expended, except as otherwise provided by a law enacted in express limitation of this section, in accordance with this chapter and other laws administered by the Veterans' Administration and without regard to any law providing for the cancellation of authority to make payments.".

### SEC. 5. HOME LOAN GUARANTIES.

(a) Subchapter III of chapter 37 is amended by adding at the end the following new section:

**"§ 1831. Laws governing guarantees of home loans**

"A loan made for a purpose described in section 1810(a) or section 1819(a)(1) of this title shall be guaranteed, except as provided by a law enacted in express limitation of this section, in accordance with this chapter and other laws administered by the Veterans' Administration and without regard to any law providing for the cancellation of authority to make loan guarantee commitments.".

(b) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1830 the following new item:

"1831. Laws governing guaranties of home loans.".

**SEC. 6. EFFECTIVE DATES.**

(a) Except as provided in subsection (b), the amendments made by and provisions of this Act shall take effect on October 1, 1986.

(b) The amendments made by sections 3 and 5 shall take effect as of March 1, 1986.

○

II

99TH CONGRESS
2D SESSION

# S. 2186

To exempt any amounts available to provide certain benefits to veterans with service-connected disabilities from any requirement for sequestration of funds under part C of the Balanced Budget and Emergency Deficit Control Act of 1985.

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## IN THE SENATE OF THE UNITED STATES

MARCH 12 (legislative day, MARCH 10), 1986

Mr. MURKOWSKI (for himself, Mr. THURMOND, Mr. SPECTER, Mr. DENTON, Mr. ABDNOR, and Mrs. HAWKINS) introduced the following bill; which was read twice and referred to the Committee on Governmental Affairs

---

# A BILL

To exempt any amounts available to provide certain benefits to veterans with service-connected disabilities from any requirement for sequestration of funds under part C of the Balanced Budget and Emergency Deficit Control Act of 1985.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That the following programs shall be exempt from reduction under any order issued under part C of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901 et seq.):

(1) Patient benefits which, under the compensated work therapy program carried out pursuant to section 618 of title 38, United States Code, are payable from the Veterans' Administration Special Therapeutic and Rehabilitation Activities Fund to veterans who have a service-connected disability.

(2) Benefits under chapter 21 of such title, relating to specially adapted housing for disabled veterans.

(3) Benefits under section 907 of such title, relating to burial benefits for veterans who die as the result of a service-connected disability.

(4) Assistance under chapter 31 of such title, relating to training and rehabilitation for veterans with service-connected disabilities, but only with respect to training and rehabilitation of veterans whose service-connected disability is rated at 50 percent or more.

(5) Benefits under chapter 39 of such title, relating to automobiles and adaptive equipment for certain disabled veterans and members of the Armed Forces.

SEC. 2. The first section shall apply with respect to any sequestration order issued for a fiscal year after fiscal year 1986.

○

II

99TH CONGRESS
2D SESSION

# S. 2187

To amend title 38, United States Code, to exempt from sequestration certain benefits for veterans and dependents and survivors of certain veterans which are paid based on the service-connected disability or death of veterans.

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IN THE SENATE OF THE UNITED STATES

MARCH 12 (legislative day, MARCH 10), 1986

Mr. DECONCINI introduced the following bill; which was read twice and referred to the Committee on Governmental Affairs

---

# A BILL

To amend title 38, United States Code, to exempt from sequestration certain benefits for veterans and dependents and survivors of certain veterans which are paid based on the service-connected disability or death of veterans.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

## SECTION 1. EXEMPTION FROM SEQUESTRATION FOR VETERANS' BENEFITS BASED ON SERVICE-CONNECTED DISABILITY.

(a)(1) Chapter 1 of title 38, United States Code, is amended by adding at the end the following new section:

### "§ 113. Preservation of funding for certain service-connected programs

"(a) In addition to compensation benefits and dependency and indemnity compensation benefits as specified in section 255(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901 et seq.) benefits based on service-connected disability or death under the following provisions shall be exempt from sequestration and reduction under any order issued under part C of such Act:

"(1) Chapter 21 of this title, relating to specially adapted housing for veterans with certain service-connected disabilities.

"(2) Section 907 of this title, relating to burial and funeral benefits in the case of veterans who die as a result of service-connected disability.

"(3) Chapter 31 of this title, relating to training and rehabilitation for certain veterans with service-connected disabilities.

"(4) Chapter 35 of this title, relating to educational assistance for the dependents of veterans with service-connected disabilities rated total and permanent and for the survivors of those who die as a result of service-connected disability.

"(5) Chapter 39 of this title, relating to automobiles and adaptive equipment for veterans with certain service-connected disabilities.

"(b) Amounts provided for in any budget account for the payment of any benefit specified in clauses (1) through (5) of subsection (a) of this section shall be excluded from the computations under part C of such Act of any amount in such account to be sequestered by, and any amount by which such account is to be reduced by, any order issued by the President under such part.".

(2) The table of sections at the beginning of such chapter is amended by adding at the end thereof the following new item:

"113. Preservation of funding for certain service-connected programs.".

(b) The amendments made by subsection (a) shall apply with respect to any order issued by the President under part C of the Balanced Budget and Emergency Deficit Control Act of 1985 with respect to any fiscal year after fiscal year 1986.

○

JUN 1 2 1986

Honorable Frank H. Murkowski
Chairman, Committee on
Veterans' Affairs
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

I am pleased to provide the Veterans Administration's (VA) views on three bills pending before your committee which would exempt certain benefits and activity funds from the impact of the Balanced Budget and Emergency Deficit Control Act of 1985.

S. 2186 and S. 2187 are similar to but less comprehensive than S. 2423, which would have the effect of exempting the following:

- Burial allowances for veterans whose deaths are service connected;
- Grants for specially adapted housing;
- Mortgage protection life insurance;
- Vocational rehabilitation and training;
- Survivors' and dependents' educational assistance;
- Assistance in purchasing automobiles and adaptive automotive equipment;
- Direct loans against policies of veterans' life insurance under programs administered by the VA;
- Laws authorizing the guaranty of home loans;
- The special therapeutic and rehabilitation activities fund; and,
- The Canteen Service revolving fund.

S. 2187 and S. 2423 would also assure that the amounts exempted under the programs and activities they cover are not considered in determining the sequestration baselines for their respective budget accounts. The life insurance and loan guaranty exemptions in S. 2423 would be retroactive to March 1, 1986, but other provisions in the three bills would be effective only with respect to any future sequestration orders.

The balanced-budget Act was a courageous attempt by the Congress to reduce Federal deficits that adversely affect all Americans, veterans included. The Congress bound itself to either adopt budget resolutions that will eventually eliminate the deficit or, failing that, to authorize broad sequestrations of funds to assure that Federal outlays do not exceed specified targets.

While it was hoped that future sequestrations would not be necessary, the framers of the Act also realized that in the event automatic cuts be required become necessary, they should be as broad (and therefore as shallow) as possible. Protections were included for VA compensation and pension recipients, whose very sustenance may depend upon their monthly benefits, and for overall VA health-care expenditures. However, with some other exceptions (most notably, Social Security) the cuts would be "across the board."

Public support for this plan is in large measure attributable to the breadth of programs subject to sequestration. As long as any resulting dislocation is widely shared, this much-deserved support will remain strong.

For that reason, the Administration opposes any exemptions for veterans' programs now clearly covered by the terms of the Act that would result in additional Government spending. There is no question but that home loan guaranties, burial allowances, vocational rehabilitation and other VA programs expressly covered by the Act are extremely valuable ones. However, we can foresee that debates over the relative merits of programs for various constituencies would generate ill will among competing interests and erode support for the Act. The current exemptions for VA benefits and services already place disabled veterans and their survivors in a deservedly preferred category.

On the other hand, the Administration would support legislation that would prospectively exempt two important veterans' programs: the special therapeutic and rehabilitation activities fund, and the Canteen Service revolving fund. These two funds are self-financing and their exemption would not adversely affect the budget deficit.

Advice has been received from the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

THOMAS K. TURNAGE
Administrator

II

99TH CONGRESS
2D SESSION

# S. 2445

To amend title 38, United States Code, to improve certain Veterans' Administration health-care programs.

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IN THE SENATE OF THE UNITED STATES

MAY 13 (legislative day, MAY 12), 1986

Mr. MURKOWSKI (for himself, Mr. SIMPSON, and Mr. THURMOND) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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# A BILL

To amend title 38, United States Code, to improve certain Veterans' Administration health-care programs.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

### SHORT TITLE; REFERENCES

SECTION 1. (a) This Act may be cited as the "Veterans' Health Care Programs Improvements Act of 1986".

(b) Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

## RESPITE CARE

SEC. 2. (a) Section 601 is amended by inserting after paragraph (8) the following new paragraph:

"(10) The term 'respite care' means care furnished on an intermittent or temporary basis by a Veterans' Administration facility to a veteran who has been diagnosed as suffering from a chronic illness and who is receiving care primarily in the veteran's home.".

(b) Section 610(a) is amended by striking out "nursing home care," and inserting in lieu thereof "nursing home care or respite care,".

(c) Not later than 180 days after the date of the enactment of this Act, the Administrator of Veterans' Affairs shall transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report describing in detail—

(1) the actions taken before the date of the report, if any, under the authority provided by the amendment made by subsection (b), and

(2) the plans for exercising such authority.

## ALTERNATIVES TO HOSPITAL OR NURSING HOME CARE

SEC. 3. (a) Section 610 is amended by adding at the end the following new subsection:

"(h)(1) The Administrator may contract to furnish hospital-based home care, when medically appropriate, to any veteran in lieu of furnishing hospital care or nursing home care to such veteran under subsection (a) of this section.

"(2) The hospital-based home care which may be furnished a veteran under paragraph (1) of this subsection may include medical, rehabilitative, social, and nutrition services.".

(b)(1) Section 620 is amended by adding at the end the following new subsection:

"(g)(1) The Administrator may contract to furnish services described in paragraph (2) of this subsection, in lieu of nursing home care under subsection (a) of this section, to any veteran who, by reason of a functional deficiency resulting from the veteran's physical or mental condition, is unable to perform a necessary activity of daily living but, considering the veteran's disability, does not require nursing home care, as determined by the Administrator.

"(2) The services which may be furnished a veteran under paragraph (1) of this subsection are the services required for the performance of any necessary activity of daily living, and may include personal care, homemaker, nutrition, and transportation services.

"(3) In administering this subsection, the Administrator shall give priority to furnishing services to a veteran—

"(A) who has a service-connected disability;

"(B) who is 65 years of age or older;

"(C) who has a total and permanent disability;

"(D) who, by reason of blindness in both eyes, has only light perception or is in need of regular aid and attendance; or

"(E) who is suffering from dementia, including Alzheimer's disease.

"(4) The total amount which may be paid for services furnished to all veterans under this subsection in any fiscal year may not exceed 60 percent of the cost which would be incurred if such veterans were furnished nursing home care under subsection (a) of this section in such fiscal year. The total of the periods for which services may be furnished to any such veteran under this subsection shall be the same as authorized for nursing home care under subsection (a) of this section.".

(2) The amendment made by paragraph (1) shall not be construed to limit or reduce the nursing home care and adult day health care programs provided in subsections (a) through (f) of section 620 of title 38, United States Code, or to encourage the limitation or reduction of such programs.

### TREATMENT AND REHABILITATION FOR CHRONICALLY MENTALLY ILL VETERANS

SEC. 4. (a) Subchapter II of chapter 17 is amended by adding at the end the following new section:

**"§ 620B. Community-based psychiatric residential treatment for chronically mentally ill veterans**

"(a) For the purposes of this section:

"(1) The term 'case management' includes the coordination and facilitation of all services furnished to a veteran by the Veterans' Administration, either directly or through a contract, including, but not limited to, screening, assessment of needs, planning, referral (including referral for services to be furnished by the Veterans' Administration, either directly or through a contract, or by an entity other than the Veterans' Administration), monitoring, reassessment, and followup.

"(2) The term 'contract facility' means any facility which has been awarded a contract under subsection (b)(1) of this section.

"(3) The term 'eligible veteran' means a veteran who, at the time of referral to a contract facility—

"(i) is being furnished hospital, domiciliary, or nursing home care from the Veterans' Administration for a chronic mental illness disability, or

"(ii) is being furnished such care from the Veterans' Administration for a chronic mental illness disability and is a veteran described in section 612(a)(1)(B) of this title.

"(b)(1) The Administrator, in furnishing hospital, nursing home, and domiciliary care and medical and rehabilitative services under this chapter, may contract for care and treatment and rehabilitative services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from chronic mental illness disabilities.

"(2) Before furnishing such care and services to any veteran through a contract facility, the Administrator shall approve (in accordance with criteria which the Administrator shall prescribe by regulation) the quality and effectiveness of the program operated by such facility for the purpose for which such veteran is to be furnished such care and services.

"(c) In the case of each eligible veteran provided care and services under this section, the Administrator shall designate a Veterans' Administration employee to provide case management services.

"(d) The Administrator may provide in-kind assistance (through the services of Veterans' Administration employees and the sharing of other Veterans' Administration resources) to a contract facility under this section. Any such in-kind assistance shall be provided under a contract between the Veterans' Administration and the contract facility. The Administrator may provide such assistance only for use solely in the furnishing of appropriate services under this section and only if, under such contract, the Veterans' Administration receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds allotted to the Veterans' Administration facility that provided the assistance.

"(e) Not later than 1 year after the date of enactment of the Veterans' Health Care Programs Improvements Act of 1986, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the experience under this section. The report shall include the Administrator's evaluation and findings regarding—

"(1) the quality of care furnished to participating veterans through contract facilities;

"(2) any medical advantages that may result from furnishing such care and services to veterans with such disabilities in such contract facilities rather than in inpatient facilities over which the Administrator has direct jurisdiction;

"(3) the effectiveness of the use of contract facilities under this section in enabling the participating veterans to live outside of Veterans' Administration inpatient facilities and to achieve independence in living and functioning in their communities;

"(4) the cost-effectiveness of furnishing such care through contract facilities under this section, including the effect on the average daily census in the Veterans' Administration hospitals, nursing homes, and domiciliary facilities participating in the program (taking into account whether the beds previously occupied by the participating veterans were subsequently occupied by other eligible veterans or remained unoccupied); and

"(5) any plans for administrative action, and any recommendations for legislation, that the Administrator considers appropriate to include in such report.".

(b) The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 620A the following new item:

"620B. Community-based psychiatric residential treatment for chronically mentally ill veterans.".

AUTHORITY TO WAIVE A LICENSURE REQUIREMENT FOR CERTAIN VETERANS' ADMINISTRATION PSYCHOLOGISTS

SEC. 5. Section 4114(d) is amended by striking out "or optometrist," both places it appears and inserting in lieu thereof "optometrist, or psychologist,".

OPERATING BED REQUIREMENTS

SEC. 6. Section 5010(a)(1) is amended—

(1) by striking out "hospital beds and nursing home beds" in the third sentence and inserting in lieu thereof "hospital, nursing home, and domiciliary beds"; and

(2) by striking out "hospital and nursing home beds" in the fourth sentence and inserting in lieu thereof "hospital, nursing home, and domiciliary beds".

STATE HOME GRANTS

SEC. 7. (a)(1) Section 5031(c) is amended to read as follows:

"(c) The term 'construction' means—

"(1) the construction of new domiciliary or nursing home buildings;

"(2) the expansion, remodeling, or alteration of existing buildings for the provision of domiciliary or nursing home care in State homes;

"(3) the remodeling or alteration of existing buildings for the provision of hospital care in State homes; and

"(4) the provision of initial equipment for any such buildings.".

(2) Section 5032 is amended to read as follows:

**"§ 5032. Declaration of purpose**

"The purpose of this subchapter is to assist the several States (1) to construct State home facilities (or to acquire facilities to be used as State home facilities) for furnishing domiciliary or nursing home care to veterans, (2) to expand, remodel, or alter existing buildings for furnishing domiciliary or nursing home care to veterans in State homes, and (3) to remodel or alter existing buildings for furnishing hospital care to veterans in State homes.".

(b)(1)(A) Subchapter III of chapter 81 is amended by adding at the end the following new section:

**"§ 5038. Priority of projects**

"(a) Sums available for grants under this subchapter shall be allocated among State home facilities construction projects in accordance with the priority established for such projects pursuant to subsection (b) of this section.

"(b) The Administrator shall prescribe criteria and procedures for determining the priority to be accorded to State home facilities construction projects with respect to which applications have been approved under section 5035 of this title.".

(B) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 5037 the following new item:

"5038. Priority of projects.".

(2) Not later than 180 days after the date of the enactment of this Act, the Administrator of Veterans' Affairs shall—

(A) develop, prescribe, and implement the criteria and procedures required by section 5038(b) of title 38, United States Code (as added by paragraph (1)); and

(B) shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report which describes such criteria and procedures and the implementation of the use of such criteria and procedures to establish the priority of construction projects referred to in such section.

(c)(1) Except as provided in paragraph (2), the amendments made by subsection (a) shall take effect with respect to applications submitted to the Administrator of Veterans' Affairs under section 5035 of title 38, United States Code, on or after October 1, 1986.

(2) The amendments made by subsection (a) shall not apply with respect to an application referred to in paragraph (1) if, before October 1, 1986, the applicant furnished any preliminary information to the Veterans' Administration relating to such application in accordance with application procedures established by the Veterans' Administration in administering subchapter III of chapter 81 of title 38, United States Code.

### IONIZING RADIATION REGISTRY

SEC. 8. (a)(1) Chapter 57 is amended by adding at the end thereof the following:

## "Subchapter III--Special Records

### "§ 3321. Ionizing Radiation Registry

"(a) The Administrator shall establish and maintain a special record to be known as the 'Ionizing Radiation Registry' (hereafter in this section referred to as the 'Registry').

"(b) The Registry shall include the following information:

"(1) Subject to subsection (c) of this section, a list containing the name of each veteran who was exposed to ionizing radiation under the conditions described in section 610(e)(1)(B) of this title and—

"(A) has requested hospital or nursing home care; or

"(B) has filed a claim for disability compensation under chapter 11 of this title or pension under section 521 of this title on the basis of a disability which may be associated with the exposure to ionizing radiation; or

"(C) has died survived by—

"(i) a spouse, child, or parent who has filed a claim for dependency and indemnity compensation under chapter 13 of this title; or "(ii) a spouse or child who has filed a claim for pension under subchapter III of chapter 15 of this title,

on the basis of the exposure of such veteran to ionizing radiation.

"(2) Medical data relating to each veteran listed in the Registry under paragraph (1) of this subsection, including the veteran's medical history, latest health status recorded by the Veterans' Administration, physical examinations, and clinical findings, and a statement describing birth defects, if any, in the natural children of the veteran.

"(3) Data on claims for the compensation and pensions referred to in paragraph (1) of this subsection, including decisions and determinations of the Veterans' Administration relating to such claims.

"(4) An estimate of the dose of radiation to which each veteran listed in the Registry under paragraph (1) of this subsection was exposed under the conditions described in section 610(e)(1)(B) of this title.

"(c) The Registry is not required to contain the name of a veteran described in subsection (b)(1) of this section if the request or claim referred to in such subsection (b)(1) which relates to such veteran was filed before the date of the enactment of the Veterans' Health Care Programs Improvements

Act of 1986, and such veteran or the survivor filing the claim (in the case of a claim referred to in clause (C) of such subsection (b)(1)) does not request the Veterans' Administration to include the veterans' name in the Registry.

"(d) For the purpose of establishing and maintaining the Registry, the Administrator shall compile and consolidate relevant information maintained by the Department of Veterans' Benefits and the Department of Medicine and Surgery of the Veterans' Administration, relevant information maintained by the Defense Nuclear Agency of the Department of Defense, and any relevant information maintained by any other subdivision of the Veterans' Administration or the Department of Defense.

"(e) The Secretary of Defense shall furnish the Administrator such information maintained by any agency of the Department of Defense as the Administrator considers necessary to establish and maintain the Registry.".

(2) The table of sections at the beginning of such chapter is amended by adding at the end the following:

"SUBCHAPTER III—SPECIAL REPORTS

"3321. Ionizing Radiation Registry.".

(b) The Administrator of Veterans' Affairs shall establish the Ionizing Radiation Registry required by section 3321 of title 38, United States Code (as added by subsection (a)), not later than 180 days after the date of the enactment of this Act.

(c)(1) Not later than 1 year after the date of the enactment of this Act, the Administrator of Veterans' Affairs shall analyze the information collected in the Ionizing Radiation Registry and transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives and to the Advisory Committee on Environmental Hazards of the Veterans' Administration a summary of the analysis.

(2) Not later than 90 days after the date on which the Administrator transmits the summary to the Committees referred to in paragraph (1), the Advisory Committee on Environmental Hazards of the Veterans' Administration shall review the analysis and transmit to the Committees on Veterans' Affairs of the Senate and the House of Representatives such comments on the analysis as the Committee considers appropriate.

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Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUL 1 1986

Honorable Frank H. Murkowski
Chairman, Committee on Veterans'
Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans' Administration (VA) on S. 2445, 99th Congress, a bill "To amend title 38, United States Code, to improve certain Veterans' Administration health-care programs."

Major provisions of S. 2445, an omnibus health care bill, would authorize VA to provide "respite care" to veterans eligible for hospital or nursing home care, authorize a program of noninstitutional care as an alternative to inpatient care, authorize a contract residential care program for chronically mentally ill veterans, alter the process by which VA awards grants for construction of State homes, and require VA to establish a registry of veterans exposed to ionizing radiation. Although we support in principle the purposes of several provisions of S. 2445, we do not, as discussed below, favor enactment of this bill.

Section 2 of the bill would authorize VA to provide needed "respite care" to veterans eligible for hospital or nursing home care. Respite care represents a relatively new concept for VA which we would prefer to evaluate on a pilot basis. In essence, "respite" care refers to providing brief periods of care in VA health facilities on a prearranged basis to chronically-ill persons in order to relieve members of the veteran's family and others in the household from the severe physical and emotional burdens of care giving. The difficulties of caring for these veterans at home often become exacerbated during the course of illness, particularly if there is no break for the family. The patient may also benefit directly from respite care by virtue of treatment received in the institution. The critical element of respite arrangements is that the respite is planned in advance for the benefit of the care giver, rather than being incidental to the provision of necessary medical care of the patient.

VA currently lacks clear statutory authority to furnish respite care. Under our respite care legislative proposal, which we would suggest as an alternative to section 2 of this bill, a program would be initiated on an evaluative, pilot basis, and its scope would be limited to those veterans having the highest claim to VA health care, service-connected veterans. Under the proposal, we would anticipate providing respite care at a limited number of facilities in conjunction with hospital based home care programs in one-week lengths of stay for up to four times a year. Care would be furnished in beds that would otherwise be unoccupied, and, since respite patients generally would receive nursing level care, these beds would be staffed accordingly. We would also limit the scale of the pilot program so that there would be no additional costs. We also believe that a three-year program would provide us with sufficient experience to determine the future of respite care by VA.

We estimate that the cost of section 2 would be $94.3 million in Fiscal Year 1987, and $471.8 million over five fiscal years.

Section 3 of the bill would authorize VA to furnish veterans with noninstitutional care on a contract basis as an alternative to inpatient hospital and nursing home care. First, it would grant the Administrator authority to furnish hospital based home care to any veteran when such care would obviate the need for inpatient care. Second, it would authorize VA to contract for nonmedical support services to assist veterans to perform necessities of daily living if such services would obviate the need for nursing home care.

VA generally favors noninstitutional alternatives to inpatient care, but we cannot support this proposal. First, it would establish virtually unlimited authority to contract for hospital based home care to any veteran. This open-ended eligibility represents a substantial departure from the longstanding statutorily based policy that, except in limited circumstances and for limited categories of veterans, VA should, as much as possible, furnish hospital and medical services to veterans in facilities under the jurisdiction of the Administrator. That is particularly true in the case of nonservice-connected veterans.

The amendment in this bill would affect far-reaching changes in the scope of hospital based home care by expanding that service substantially to include social support services, such as homemaker or chore services. Similarly, the bill would amend section 620 of title 38 to authorize an even broader array of nonmedical services necessary to help any veteran with a "functional deficiency" perform tasks of daily living.

3.

Honorable Frank H. Murkowski

As we have stated on several occasions in commenting on similar legislative proposals, Congress has provided, in 38 U.S.C. § 4101, that "[the] primary function of the Department of Medicine and Surgery shall be to provide a complete medical and hospital service." That mandate contemplates that VA will provide veterans with all needed medical services, either in VA operated facilities, or in limited circumstances when necessary, in facilities for which the VA contracts. Furnishing homemaker and transportation services, and personal care services such as feeding, washing, and dressing duplicates, in large measure, the assistance for which the basic aid and attendance allowances are currently paid to many veterans. It would also duplicate the availability of such services which are often available from community resources. We do not recommend a departure from the longstanding public policy that the Department of Medicine and Surgery be responsible for medical services for veterans, while other needs be met by other benefits or resources in the community.

We estimate the cost of section 3 would be $572.6 million in the first fiscal year, and $2.86 billion over five fiscal years.

Section 4 of the bill would authorize VA to contract with community residential treatment facilities for the care of veterans who are being furnished VA inpatient care for chronic mental illness. VA has been studying this concept, and, in general, we favor the enactment of a provision which would grant us the contracting flexibility which prevails in our drug and alcohol dependence treatment program under which we have a broad network of contract arrangements for providing halfway house care. This has proven a cost-effective approach, which, in our judgment, could be applied here to diminish substantially lengthy hospital stays for many veterans suffering from chronic mental illness. As such, it would free-up $3.87 million dollars in resources which can be used for other purposes.

We would urge the committee to modify this measure, however, to eliminate elements which are unnecessarily restrictive. Specifically, we recommend that the provision requiring VA to furnish case management services be deleted. We note as well that this measure would require VA to provide a relatively detailed report on the agency's experience with this authority within a year after enactment of this provision. Since the measure requires VA to promulgate regulations prior to contracting for services, it is highly unlikely that we can both implement this program meaningfully and evaluate its effectiveness in this timeframe. We would also recommend that this program be initially authorized for three years and would recommend that an evaluative report be submitted 24 months after enactment.

We estimate that the cost of section 4 would be $.5 million in the first fiscal year, and $2.5 million over five fiscal years.

Section 5 of the bill would amend section 4114(d) of title 38 to permit VA to appoint psychologists who are not licensed in a "State" if they will be working in a research or academic post where they have no patient care responsibility. Currently VA has identical authority to hire physicians, dentists, podiatrists, and optometrists who are not licensed in a State, which has proven helpful.

VA supports the intent of this proposal which appears to be to give VA more flexibility in the hiring of research psychologists. We would recommend one additional flexibility provision be built into the bill. We suggest that authority be granted to waive the internship requirement for psychologists included in section 4105(a)(8), and that VA be authorized to hire such research psychologists using only term appointments lasting for as long as their research would continue.

We estimate that enactment of section 5 would not impose new costs on the VA.

Section 6 of the bill would amend the statutory provision directing VA to operate 90,000 hospital and nursing home beds to include domiciliary beds within that formulation. With the inclusion of domiciliary beds VA would be above the 90,000 operating bed level. Since the original 90,000 bed minimum was enacted, dramatic changes have taken place in the delivery of medical care. These changes, such as increased outpatient care, including minor surgery on an outpatient basis, have diminished the need for inpatient hospital stays. If the Congress continues to believe that a total minimum number of beds is needed, we do favor the addition of domiciliary beds.

We estimate that enactment of section 6 would not impose new costs on the VA.

Section 7 of the bill would very substantially change the process by which VA funds are awarded to applicants for State home grants. Under existing law, the VA must approve a grant application if that application meets the requirements set by law. The statute leaves us little discretion to rank grant applications according to priorities or "established priority." As a result, the VA approves grants as funds become available in the order in which grant requests are received.

Under this proposal, VA would be required to grant awards on the basis of pre-established criteria for prioritizing projects. The bill calls for VA to develop those criteria and to make its relative priority determinations from among approved applications. Monies available for these grants would then be allocated among those approved projects in accordance with the priorities that had been established. Enactment of this proposal would revise a longstanding process, and may act to discourage some States from applying for State home construction grants while encouraging others to apply. As drafted, this measure appears to require a State to incur all the expense associated with submitting a formal application (up to 10% of the project's cost) and await project approval, without any assurance that that project, even if approved, will be funded. Because of this uncertainty, we anticipate that some States may be less likely to plan and request funding for State home projects if this proposal were enacted.

We recognize that there is criticism that the existing process does not give sufficient weight to relative need among State home projects. Allowing VA to target grant money to areas of greatest need could encourage some non-participating States to submit applications. An effective targeting provision could be a useful tool in assisting the VA to better manage its nursing home provider mix. Although we believe it is premature to make any decision to change the current approval process at this time, there may be options similar to the concept contained in this bill, which would provide additional flexibility. However, all of the ramifications of these options should be considered before a change is made to the existing procedure.

Section 7 would also limit the existing scope of grant-eligible projects under the State home program. As proposed, construction grants would no longer be available to assist States to expand existing buildings for the provision of hospital care in

State homes. In view of the pressing need for long-term care facilities, we have no objection to this provision.

We estimate that enactment of section 7 would not impose significant costs.

Section 8 of the bill would require that the Veterans Administration establish a registry of veterans exposed to ionizing radiation who have requested VA care for disabilities which may be related to such exposure, who have claimed VA disability compensation for disabilities allegedly resulting from radiation exposure, or who died leaving survivors who have claimed VA death benefits based on the veteran's exposure to radiation. The registry would be required to include, for each veteran, detailed medical data identified in the bill, data on the veteran's benefits claim, and an estimate of the radiation dose the veteran received. Finally, the VA would be required to analyze the registry data and report to the Congress regarding the analysis, and the Advisory Committee on Environmental Hazards would be required to review and comment on the analysis.

We support the concept embodied in this proposal for a registry, which is to assure access to information regarding veterans exposed to ionizing radiation. We cannot support this specific proposal, however. Most of the information which the proposed registry would include is now available to the VA, but it is often not easily accessible. For example, VA has established a method for identifying veterans who apply to the VA for inpatient care for disabilities possibly related to exposure to radiation. This system permits us to retrieve from the VA's automated Patient Treatment File summary data concerning these veterans and the location of their permanent medical records. Similarly, the Department of Veterans Benefits established a Special Issue Rating System (SIRS) which collects data on claims based on exposure to ionizing radiation. This system includes service dates, the disabilities claimed, the VA's decision on each disability with respect to service-connection, and the date of the latest rating decision.

We recommend that as an alternative to the registry proposed in this bill, the VA develop a more limited registry which would, in effect, permit VA greater access to the information which is already available. The registry would also combine information from the Defense Nuclear Agency with information in existing VA files. Development of this more limited registry would be more cost-effective than the proposal made in this bill, and would provide the information that the VA, the Congress, and the affected veteran population need.

We also cannot support the provision in this bill which would require VA to analyze the data in the proposed registry and report to the Congress regarding the analysis. This provision could be construed as requiring that VA perform a morbidity study of veterans included in the ionizing radiation registry. It has already been determined by the Office of Technology Assessment and the Committee on Interagency Radiation Research and Policy Coordination that such a study, in any form, would not be feasible.

We estimate that the costs of section 8 of the bill would be $.3 million in the first fiscal year and $.7 million over five fiscal years. We estimate that the total costs of S. 2445 would be approximately $667.7 million in Fiscal Year 1987, and $3.34 billion over the first five fiscal years.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

THOMAS K. TURNAGE
Administrator

BLINDED VETERANS ASSOCIATION
1735 DeSALES STREET, NORTHWEST • WASHINGTON, D.C. 20036 • (202) 347-4010

June 22, 1986

The Honorable Frank H. Murkowski
Chairman
U.S. Senate Committee on Veterans' Affairs
709 Senate Hart Office Building
Washington, D.C. 20510-0201

Dear Chairman Murkowski:

The Blinded Veterans Association would like to take this opportunity to express its support for S. 2445, The Veterans Health Care Program Improvement Act of 1986. We feel there are several provisions in this legislation that are quite innovative and progressive and are very deserving of favorable legislative action.

We strongly support the provision that would provide for Respite Care for terminally or chronically ill veterans. This is a very compassionate and progressive approach to providing health care services to those categories of veterans, as well as providing much needed relief to the health care providers in the veteran's home. It also appears to be a very effective way to make more beds available in VAMC's and nursing homes for other veterans in need of acute care.

The BVA, as you might imagine, has a special interest in the provision of this bill which provides for alternatives to hospitalization or nursing home placement. This provision enables the Administrator to contract to furnish Hospital Based Home Care (HBHC) when medically appropriate to care for veterans in lieu of hospital or nursing home care. Certain services could, under this amendment, be provided for those veterans who, because of their physical or mental disabilities experience a functional deficiency that makes them unable to perform activities of daily living. Services specifically referred to in this section are Personal Care, Home Maker Service, Nutrition Services and Transportation.

In addition to supporting this provision which gives special priority to blinded veterans, we would like to request clarification of the scope of services that might be covered by contract. As we have indicated in our testimony over the past few years, there are a number of services that if provided at the local level would enable that veteran to remain in his home rather than seek placement in a VAMC or a nursing home solely because of his blindness. This is especially true of the older veteran who is becoming blind and for whatever reason is not appropriate for blind rehabilitation training at a VA Blind Rehabilitation Center or Clinic. This could also apply to a blinded veteran who is getting older and might need a refresher course in blind rehabilitation but does not want to leave home for an extended period or who does not require a comprehensive rehabilitation program. Such services might be low vision evaluation and the provision of low vision devices that would enable the veteran to maximize his remaining vision to the extent he could then perform necessary activities of daily living independently or at best limit the need for assistance provided under contract. Other services might be reader services that could assist the veteran with taking care of his bills and other correspondence and generally managing his personal business, Home Maker service that could assist in meal preparation especially if unusual or special diets are required, and finally, home repairs of a minor nature but necessary for the veteran to have a safe and functional home. The latter would be repairs that would normally be undertaken by the average home owner but the veteran's blindness might preclude his accomplishing the task.

All of the above examples fall under the general category of activities of daily living which are often taken for granted by sighted individuals but which, if not provided for, would make it highly unlikely that many blinded veterans could continue to live alone or with a spouse who was unable to perform these tasks either. Our question then, is, could these kinds of services be included under the categories of service described in this amendment or would it be necessary to broaden the language? Also, I would appreciate clarification of the term "Transportation" as used in the bill. Could this mean transportation to medical appointments or shopping or is it more limited?

Finally, we would like to strongly support the Pilot Project proposed by the VA regarding aftercare of long term psychiatric patients in Region 1. This is a very innovative approach to psychiatric care that has been very successful in other countries and is deserving of a pilot project to determine if it can be of equal benefit in the treatment of our veterans who fall into this category. It is our understanding that Region 1 has made funds available for the project but that legislative help is needed to enable physicians and other health care professionals to provide treatment in nursing homes or other facilities.

Again, thank you for this opportunity to present the views of the BVA on this important piece of legislation and for all your assistance in the past in advancing the quality of life for all blinded veterans. As always we are available to work with you and your staff on this or any legislation or issue of concern to blinded veterans.

Very Sincerely,

Thomas H. Miller, Director
Governmental and Community Relations

cc: Sen. Alan Cranston

PVA

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

June 24, 1986

The Honorable Frank H. Murkowski, Chairman
Senate Committee on Veterans' Affairs
709 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Murkowski:

PVA is pleased to respond to your request for the views of this organization regarding the proposed organization of the Office of Chief Medical Director. (Section 4103, of title 38, United States Code).

PVA supports revising the qualifications of all appointees under Section 4103 to include persons, each of whom shall be qualified in the administration of health services. We believe this qualification to be an important element in the management of the Department of Medicine & Surgery. However, PVA opposes the removal of the physician and/or dentist limitation.

PVA recognizes the quality and expertise that can be afforded to DM&S through the appointment of certain non-physician health professionals, but we would prefer some system of prior notification of the Administrator's intention to appoint those persons not meeting the physician and/or dentist requirements. PVA would recommend the prior submission of these applicants' qualifications to the Chairmen of the Committees on Veterans Affairs and ideally the respective Ranking Minority Members for informal concurrence and approval. PVA recognizes that in certain instances, positions within the Office of the Chief Medical Director could be appropriately executed by non-physician health professionals and we applaud your efforts.

Further under section 4103, paragraph 7, PVA supports legislative mandate for Directors of Pharmacy Service and Dietetic Service as we believe these services are vital to the Department of Medicine & Surgery. PVA would support Directors of Podiatry and Optometry but believe that these positions be appointed as deemed necessary by the Department of Medicine & Surgery in order to carry out its mission.

We support the licensure requirement in appropriate service fields as a prerequisite to these and all positions requiring specialization in the Office of the Chief Medical Director.

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300

Senator Frank H. Murkowski
June 24, 1986
Page Two

The proposal rightfully maintains an Assistant Chief Medical Director for Geriatrics. However, PVA believes the specified qualifications for this position remain a qualified medical doctor, trained in geriatrics. Finally, PVA supports the provision for one additional Associate Chief Medical Director.

Again, thank you for the opportunity to express the views of PVA on this and all proposed legislation affecting our nation's veterans.

Sincerely yours,

R. Jack Powell
Executive Director

GAO

United States
General Accounting Office
Washington, D.C. 20548

Comptroller General
of the United States

B-201752

June 25, 1986

The Honorable Frank H. Murkowski
Chairman, Committee on Veterans' Affairs
United States Senate

Dear Mr. Chairman:

The Senate Committee on Veterans' Affairs is considering several pieces of legislation regarding the Veterans Administration's (VA's) health care system. Our prior and current work has involved some of the programs addressed by the Committee. The following comments are provided for your use in considering proposed changes to VA's domiciliary and state home construction grant programs contained in S. 2388 and S. 2445.

## DOMICILIARY ELIGIBILITY CRITERIA

Section 5 of S. 2388, the "Veterans' Administration Health-Care Program Extension and Improvement Act of 1986," would amend 38 U.S.C. 610 to authorize VA to provide domiciliary care to veterans in need of such care for the purpose of treatment or rehabilitation. The proposal would limit eligibility to veterans with service-connected disabilities or those who are incapacitated from earning a living and have no adequate means of support. In his remarks upon introducing this provision, Senator Cranston called the existing eligibility requirements "both terribly confusing as well as not consistent with current VA philosophy and practice."

In an ongoing review of VA's domiciliary program, we found confusion over not only the eligibility criteria but also the basic mission of the program. Essentially, the issue appears to be whether the domiciliaries should provide both custodial and rehabilitative care (as they traditionally have) or restrict admission to patients with rehabilitation potential (as called for in a March 30, 1983, letter to VA medical center directors from the Chief Medical Director).

At 3 of VA's 16 domiciliaries, we selected a sample of veterans admitted in fiscal years 1984 and 1985 and applied medical eligibility criteria that we believe were consistent with the rehabilitation mission called for in 1983. Based on work completed to date, we found that 31 of 142 veterans whose files we reviewed did not have rehabilitation potential. Our discussions with VA staff indicate that the veterans were admitted (1) for humanitarian reasons or (2) because VA officials believed they needed institutional care and the domiciliary was the least costly alternative. We also found that 41 of the 142 veterans were admitted even though they did not meet the financial eligibility criteria established by VA in the Code of Federal Regulations (38 C.F.R. 17.47(c)(3), 17.48(b)(2)) and did not have the medical center director determine that other circumstances justified admission. Many of these admissions occurred without regard to the regulation's income limitation ($415 per month). VA and OMB officials have considered revising the income limitation, but have not made any proposals.

While we support the Committee's efforts to clarify the eligibility criteria for the domiciliary program, we suggest that, in addition, the Committee should give VA guidance (in the legislation or accompanying reports) as to whether VA is authorized to provide custodial care through the domiciliary program and how VA should judge veterans' capacity to earn a living and adequately support themselves.

## STATE HOME CONSTRUCTION GRANT PROGRAM

Section 7 of S. 2445, the "Veterans Health Care Improvements Act of 1986," would change the process by which VA approves and awards grants to states for veterans' home construction projects. In a 1972 report to the VA Administrator on the provision of nursing home care in state-operated veterans' homes (B-167656, Sept. 14, 1972) and a 1981 report to Senator Cranston, State Veterans Homes: Opportunities to Reduce VA and State Costs and Improve Program Management (HRD-82-7, Oct. 22, 1981), we pointed out that VA had not been basing its approval and award of these grants on the need for the projects.

VA continues to award grants in the order in which applications are received, subject only to the availability of funds. Although VA told us in 1981 that it lacked legal authority to assess the need for a particular construction project (a claim it made again in commenting on S. 2445), we cited two provisions in Title 38 that we believed required VA to assess each project before approving and funding the application:

—38 U.S.C. 5034(1) requires that the Administrator establish "the number of beds required to provide adequate nursing home care to veterans residing in each State."

—38 U.S.C. 5035(b) requires that the Administrator not approve applications unless he finds that, among other things, the project will not result in more beds than determined to be needed in that state.

The proposed legislation would add a new section to Title 38 requiring the Administrator to prescribe criteria by which VA will determine priority for funding state home construction projects. We support this proposed legislation. We believe that, if the legislation is enacted, the Administrator should include need as one criterion by which VA will judge proposed state veterans' home projects.

Sincerely yours,

Charles A. Bowsher

Charles A. Bowsher
Comptroller General
of the United States

American
Psychiatric
Association

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*Deputy Director, Business Administration*

June 26, 1986

The Honorable Frank H. Murkowski
Chairman
Senate Veterans Affairs Committee
414 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Murkowski:

The American Psychiatric Association, a medical specialty society representing over 32,000 psychiatrists nationwide, would like to express our support for Title II, Section 202 of S. 2422, providing for a community-based psychiatric residential treatment program for chronically mentally ill veterans, and for the efforts of the Veterans Administration in developing ambulatory and community-based treatment options for veterans with long term psychiatric problems.

Many studies have documented the value of providing psychiatric care in non-hospital bed settings for appropriate veterans. The development of mental health crisis teams, community treatment teams and nursing home support teams can provide support and care to patients during the transition from long term hospital care to community-based programs, provide continuing treatment by visiting veterans in their new community settings, and provide intense intervention services and emergency psychiatric care to prevent or limit decompensation. These teams can provide essential treatment, medication supervision and therapeutic support for the patient and significant others in the residential environment to prevent clinical deterioration and rehospitalization. The nursing home and elderly housing support teams will provide on site support and treatment to veterans in contract and noncontract nursing homes. These teams can provide consultation on the management of psychiatric veteran patients and will facilitate the transfer of patients back to the hospital for brief hospitalization, when needed, as well as facilitate the veterans' subsequent return to nursing homes as soon as it is medically possible.

We are in complete agreement with the intent of these programs and believe they will enhance the VA's capability to provide comprehensive psychiatric care to this population of patients.

Sincerely,

Melvin Sabshin

Melvin Sabshin, M.D.
Medical Director

MS/pr/mg

cc: Members, Senate Veterans Affairs Committee

## NATIONAL ASSOCIATION OF STATE VETERANS HOMES

Written Testimony for the Record concerning Hearings on various bills relating to veterans' health care, principally affecting the State Veterans Homes Program, held by the Senate Veterans Affairs Committee on May 20, 1986.

S. 1536--a bill to provide that per diem subsidies paid by the Veterans Administration for care of veterans in state homes shall not be used to offset payments that are made under the Medicaid program for the purposes of assisting eligible veterans.

The National Association of State Veterans Homes voted as a body at the Thirty-Third Annual Conference in Omaha, Nebraska, on July 28-31, 1985, to oppose the concept embodied in S. 1536.

The federal government established this relationship with state veterans homes before the turn of the century in the form of paying a subsidy to these homes for the care of veterans. That subsidy has evolved from a flat fee per veteran per year to the current payment of a per diem for each day of care in any of the three categories, i.e., domiciliary, nursing care, or hospital care, provided to eligible veterans by state veterans homes. Through this mechanism, the federal government has traditionally participated in the cost of caring for eligible veterans. The individual states have made up the remainder of these costs in a variety of ways, most typically through a state appropriation and collecting from the income of the veterans being provided care.

The action suggested in S. 1536 to not count the Veterans Administration per diem payments as third-party offset against Medicaid payments would, in effect, put the federal government in the position of paying twice for each day of care provided to an eligible veteran--once through the VA per diem payment and once through the federal participation in Medicaid payment. It is the position of the National Association of State Veterans Homes that paying twice for each day of care is poor public policy per se. It is entirely possible that many states given this opportunity for dual funding of veterans' care would require their state veterans homes to become Medicaid participants and merely use the VA per diem as a means of reducing or eliminating state support for veterans homes. The National Association of State Veterans Homes does not believe such action would be in the best interest of either the veteran patient or the state/federal relationship which is currently embodied in the operation of most state veterans homes. In the event such mandatory participation became the rule in the totality of state veterans homes, the cost to the federal government would significantly exceed the estimates prepared by the Congressional Budget Office for Senator Mitchell of Maine (attached). Exhibit A

The National Association of State Veterans Homes respectfully suggests to the Senate Veterans Affairs Committee that S. 1536 be defeated.

A solution to S. 1536 would be approved for a per diem increase in the rates paid to state veterans homes as proposed by the National Association of State Veterans Homes (attached). Exhibit B

S. 2445--the proposed "Veterans Health Care Programs Improvements Act of 1986". Section 7--Revision of State Home Grant Program.

On April 22, 1986, members of the Legislative Committee, National Association of State Veterans Homes, submitted their views, written and oral, pertinent to the above topic and other programmatic concerns to the Subcommittee on Hospitals and Health Care, House Veterans Affairs Committee. A copy of the Written and Oral Testimony is attached. Exhibit C

Section 7 would also limit the existing scope of grant-eligible projects under the State Veterans Home Program. As proposed, construction grants would no longer be available to assist states to expand existing buildings for the provision of hospital care in state veterans homes. It should be noted that there are presently only seven homes providing such care. In analysis of eligible preapplications and applications for grants for construction of state extended care programs as of 2/28/86, it is found that the listed projects contain no state wishing to increase or expand in the area of providing hospital care. It is important, however, that all the state veterans home facilities have the same opportunity to obtain funding for renovation and remodeling of support and existing care facilities to meet the Regulatory Agencies' requirements for providing the levels of care for which the homes have been approved (attached). Exhibit D

Section 12 of S. 2388 would extend, for three years, the Veterans Administration's authority to provide grants to states for construction or acquisition of state home facilities for furnishing domiciliary and nursing home care, and for remodeling or renovation of state home facilities for furnishing hospital, domiciliary, and nursing home care. The authority for such a program expires at the end of this fiscal year. The National Association of State Veterans Homes strongly supports the extension of the construction grant program. We would hope that the committee would consider a five year extension rather than three.

Attachment

Submitted by:
Jack J Dack
Jack J. Dack, Chairman
National Association of
State Veterans Homes
Legislative Committee
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158

June 4, 1986

cently ruled that VA per diem payments to State homes must be treated as a third party liability for purposes of Medicaid.

The result of this ruling is that State agencies which are entrusted with the responsibility of administering Medicaid, in the case of my State, the Maine Department of Human Services, are forced to reduce the Medicaid payments to the home by an amount equal to the VA per diem payments made on behalf of the Medicaid-eligible veterans residing in the home.

But the veterans throughout Maine argue that the VA per diem should not be considered a resource of the individual because the VA makes the payment to the home, not the individual veteran. Under Medicaid statutes, 42 U.S.C. 1396a(25) third-party liability is to be considered "as a resource of the individual on whose behalf the care and services are made available."

Veterans in my State have repeatedly and strongly voiced their objection to the present arrangement. They argue that it makes no sense for the Congress to authorize the Veterans' Administration to make payments to State veterans homes on behalf of veterans only to have those funds used by State agencies to replace State and Federal Medicaid dollars, with no benefit to the veteran.

The legislation I am introducing today with Senator Cohen is simple and straight-forward. It says that payments made to State veteran homes under section 641 of title 38 shall not be considered to be a third-party liability under Medicaid.

Mr. President, this question first came to my attention in December 1983. It is a question which has taken a great deal of my time since then as the debate on this question has raged in my State.

During the months of 1984 and 1985, the board of directors of the Maine Veterans Home has worked many, many hours in trying to get the present situation reversed. They have made their case to the Maine Department of Human Services and the Maine Legislature without success. The board has solicited the support of the Veterans' Administration and the Department of Health and Human Services. But all to no avail.

The introduction of this legislation stands as a testimony to the dedication the Maine veterans community, especially the board of directors of the Maine Veterans Home, toward Maine's elderly veterans and their spouses.

The home's board has persevered. For 2 years they have argued their case convincingly to me and the other members of the Maine congressional delegation. The introduction of this legislation is an important first step. I look forward to its enactment.

Mr. President, I ask unanimous consent that the text of the bill and a letter from the Congressional Budget Office regarding the impact the enactment of the bill would have on the Federal Medicaid Program be printed in the Record.

There being no objection, the material was ordered to be printed in the Record, as follows:

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That section 641 of title 38, United States Code, is amended by adding at the end thereof the following new subsection:

"(d) Payments made to States pursuant to this section—

"(1) shall not be considered to be a third-party liability for any purpose under section 1902(a)(26) of title XIX of the Social Security Act; and

"(2) shall, for purposes of determining under title XIX of the Social Security Act the reasonable costs of services provided by a State home, not be deducted directly or indirectly from the operating or other costs of such State home."

---

U.S. Congress,
Congressional Budget Office,
*Washington, DC, June 14, 1985.*

Hon. George J. Mitchell,
*U.S. Senate, Washington, DC.*

Dear Senator: As you requested in your letter of May 6, 1985, we have reviewed your proposed legislation to amend Title 38, United States Code, to provide that per diem subsidies paid by the Veterans Administration for the care of veterans in State homes shall not be used to offset reimbursements to the home under the Medicaid program. Based on our analysis, we estimate that enactment would increase federal Medicaid costs by $2 million a year. State Medicaid costs would increase by a similar amount.

Our estimate is based on current Medicaid enrollment at those homes that would be affected by this proposal. Currently only four Medicaid-certified state nursing homes care for veterans who are Medicaid recipients: Homelake, Colorado has 17 such veterans; Augusta, Maine has 96; Oxford, New York has 109; and King, Wisconsin has 280. If the Veterans Administration subsidies were not considered third-party liabilities, then the Medicaid program would be required to pick up these costs. Depending upon the match rate, the federal government would pay varying shares of the costs in each state. The estimate assumes that no additional state homes would apply for Medicaid certification as a result of this proposal. If additional state homes did apply, the costs could be significantly above those estimated.

We would be pleased to respond to any questions you might have on this estimate. Your staff may contact Anne Manley (226-2820) with detailed questions.

With best wishes,

Sincerely,

Eric Hanushek,
(for Rudolph G. Penner.) ●

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● Mr. COHEN. Mr. President, for some 4 years, the Maine Veterans Home has provided essential care to older veterans in Maine. Founded through the cooperative efforts of the Maine veterans community, Maine State officials, the Veterans' Administration, and the Maine congressional delegation, the home has earned much respect for the quality services it provides. The administrators of the home, however, are now concerned that a series of legal rulings may impair the future ability of the home to offer its veteran residents the high quality of care to which the home is committed.

The Maine Veterans Home is an intermediate care facility licensed by the State of Maine and provides services to Medicaid-eligible individuals under the Maine Medical Assistance Program. The home is certified by the Veterans' Administration to provide intermediate care to veterans and, as such, receives a per diem subsidy from the VA for each day of care provided to each veteran patient. The subsidy is authorized by 38 U.S.C., section 641.

The State of Maine Department of Human Services is the sole agency in the State of Maine authorized to administer the Medicaid Program. The Department last year ruled that the portion of the VA subsidy received by the home based on care provided to its Medicaid patients constitutes a third-party liability as defined in 42 USC, section 1396(a)(25), and 42 CFR, sections 433.135 through 433.154. Because the Department views the VA subsidy as a third-part liability, it has offset Medicaid payments otherwise due the home by the amount of the VA subsidy.

The administrators of the Maine Veterans Home questioned this offset practice on two grounds. First, the Maine Department of Human Services' ruling was based on a 1979 Federal decision whose legality the home questioned. That decision was made by the U.S. Department of Health and Human Services' Audit Office with regards to the Wisconsin Veterans Home. Second, the home argued that the offset practice was not in consonance with the intent of Congress with regards to the VA subsidy program.

To ensure a full hearing on the first of these questions raised by the administrators of the Maine Veterans Home, the Maine congressional delegation asked Secretary Heckler to review whether the VA subsidy should be considered a third party liability which must be offset. Earlier this summer, Secretary Heckler affirmed the consistency of the offset practice with HHS's interpretation of the applicable law and regulations.

This leaves the question of whether this interpretation is consistent with the intent of Congress. After careful consideration, the Maine congressional delegation has decided that the most appropriate means to evaluate this and to obtain timely congressional oversight of the situation as it affects other Medicaid-certified State veterans nursing homes would be through hearings to consider legislation to alter this offset practice.

Accordingly, Senator Mitchell and I are introducing legislation today which would provide that VA per diem subsidies authorized under 38 USC, section 641 not be considered a third-party liability under section 1902(a)(26) of title XIX of the Social Security Act. This legislation further

FEBRUARY 4, 1986 EXHIBIT B

## NATIONAL ASSOCIATION OF STATE VETERANS HOMES

## SUPPORT RATIONALE FOR A PROPOSAL BY THE NATIONAL ASSOCIATION OF STATE VETERANS HOMES FOR AN INCREASE IN PER DIEM PAYMENTS FROM THE VETERANS ADMINISTRATION.

The National Association of State Veterans Homes respectfully requests that the per diem rates paid by the Veterans Administration to the states for the care of eligible veterans within State Veterans Homes be established in the 1987 Veterans Administration budget at $23.60 per day for nursing home care, $14.10 per day for domiciliary care and $76.25 per day for hospital care. In reviewing the federal-state partnership which exists through the Veterans Administration-State Home Program, the Congress has traditionally held that the Veterans Administration rate should be 30 percent of the average daily rate of all homes participating in the State Home Program. Public Law No. 98-160 established that the adequacy of the rates paid to the state homes would be reviewed by the Veterans Administration every third year. The first such report is to be submitted not later than June 30, 1986.

With this in mind, the National Association in developing this request, took the period 1987 through 1989 and established the rate at the estimated mid-point of the triennial review period. The law already provides that in no case shall the payments made with respect to any veteran exceed one-half of the cost of the veteran's care in a State Home.

Published comments on the draft of the Executive Order 1987 Budget indicate that the proposal calls for a "new long-term care policy," emphasizing the use of community nursing homes and state institutions rather than additional federal facilities. The State Home Program has for years proven itself a high quality, cost-effective alternative to the direct provision of care in federal facilities, a fact which the Executive Budget seems to recognize. However,

EXHIBIT B

this recognition comes at a time when several state home facilities are dealing with hiring freezes, budget cuts and similar restrictive measures reflecting fiscal problems being encountered by many states. Continuation of the current per diem rate will be seen as a further disincentive to both the full operation of existing state home facilities and the creation of the needed additional beds to accommodate the large and rapidly aging population of World War II veterans now coming into our facilities in significant numbers.

The National Association of State Veterans Homes notes, according to the Consumer Price Index, December 1985, a national inflation rate in health care services hovering around 6.8 percent with a longitudinal appearance of an upward spiral. The experience of the state home facilities further demonstrates their cost-effectiveness in that state homes are experiencing a 6.42 percent annual inflation rate. This inflation rate is built into the base calculations for the rates being requested.

The attached table illustrates the calculation base used by the National Association of State Veterans Homes in determining the requested rates. We observe that all rates are currently well below the 30 percent target share and further note that the soon-to-be-finalized Veterans Administration Regulations changing the focus of domiciliary care to a rehabilitative mode carry a strong potential for adverse impact on the cost of operations of state home domiciliaries.

It is important to note the role which the state home program plays in the overall scope of long-term care provided to veterans. The Veterans Administration nursing home units are increasingly focusing their efforts on the short-term

EXHIBIT B

rehabilitation of hospitalized veterans. Care in community contract homes is normally limited to a period of six months with some options for renewal. The care furnished by the state veterans facilities is typically for severely disabled or impaired veterans who demonstrate a need for receiving nursing care over a protracted period of time, thus placing the state homes in the unique position of caring for severely debilitated patients requiring extensive amounts of care over a long-term period.

This has become increasingly noticeable with the advent of the Diagnosis Related Groups (DRG) concept of providing care in community acute care facilities and presently being implemented in the Veterans Administration Medical Centers. Without an adequate federal reimbursement structure for the states sponsoring state veterans homes, the expansion and/or full utilization of present capacity required for this long-term nursing care will not exist at that precise time in history when it is most critically needed.

It is thus that the National Association of State Veterans Homes urges your serious consideration and your subsequent approval of this request for improved per diem payments from the Veterans Administration to states for health care services provided veterans within state veterans facilities.

Jack J Dack

Jack J. Dack, Commandant
Iowa Veterans Home
Marshalltown, Iowa
Legislative Chairperson
National Association of
State Veterans Homes

JJD:rah

Attachment

EXHIBIT B

## NATIONAL ASSOCIATION OF STATE VETERANS HOMES

## COMPARISON OF VETERANS ADMINISTRATION AND STATE HOME ACTUAL COSTS, PER DIEM PAYMENTS AND ESTIMATED COSTS

## FOR THE YEARS ENDING SEPTEMBER 30, 1984 THROUGH 1989

| | 1984 | | 1985 | | 1986 | | 1987 | 1988 | 1989 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual Aver. VA Payments or Costs | Actual Aver. State Home Costs | Actual Aver. VA Payments or Costs | Actual Aver. State Home Costs | Estimated Aver. VA Payments or Costs | Estimated Aver. State Home Costs (1) | Estimated Aver. State Home Costs (1) | Estimated Aver. State Home Costs (1) | Estimated Aver. State Home Costs (1) | 30% of 87-88 Avg.(2) | Per Diem Rate To Be Request (2) |
| NURSING HOME CARE: | | | | | | | | | | | |
| Veterans Administration | $ 107.84* | | $ 111.94 | | $ 113.86 | | $ 120.04 | | | | |
| Community Contract | $ 55.19* | | $ 59.87 | | $ 64.38 | | $ 69.53 | | | | |
| State Home Program | $ 14.60 | $ 60.84 | $ 17.05 | $ 65.39 | $ 17.05 | $ 69.24 | $ 73.74 | $ 78.53 | $ 83.63 | $ 23.59 | $ 23.60 |
| Percentage of VA Payment to State Home Costs | | 24.00% | | 26.07% | | 24.62% | | | | | |
| DOMICILIARY CARE: | | | | | | | | | | | |
| Veterans Administration | $ 41.65* | | $ 43.62 | | $ 44.70 | | $ 45.11 | | | | |
| State Home Program | $ 7.10 | $ 37.61 | $ 7.30 | $ 37.62 | $ 7.30 | $ 41.42 | $ 44.11 | $ 46.98 | $ 50.03 | $ 14.11 | $ 14.10 |
| Percentage of VA Payment to State Home Costs | | 18.88% | | 19.40% | | 17.62% | | | | | |
| HOSPITAL CARE: | | | | | | | | | | | |
| Veterans Administration Intermediate Care Beds | $ 122.39** | | $ 135.22 | | $ 141.02 | | $ 145.09 | | | | |
| State Home Program | $ 13.84 | $ 198.16 | $ 15.25 | $ 210.15 | $ 15.25 | $ 223.81 | $ 238.36 | $ 253.85 | $ 270.35 | $ 76.26 | $ 76.25 |
| Percentage of VA Payment to State Home Costs | | 6.98% | | 7.26% | | 6.81% | | | | | |

NOTES: (1) The State Home Program estimated costs are based on an annual inflation rate of 6.5% and was arrived at using the current cost data.

(2) Historically the per diem rate paid by the V.A. has been based on 30% of the average daily rate of all homes participating in the State Home Program.

* Summary of medical programs September, 1985, VA Office of Information, Management and Statistics.
** Medical programs Fiscal Year 1986 Volume II Office of Budget and Finance (Controller), Washington, D.C.

EXHIBIT C

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

# TESTIMONY

April 22, 1986

To The
Subcommittee Hospitals and Health Care
on Veterans' Affairs

UNITED STATES HOUSE OF REPRESENTATIVES

Support for Legislation to Extend the Authority for the Program of Construction Grants to States for State Home Facilities: "Older Veterans Health Amendments and the Extension of the Authority of Certain Medical Programs".

Submitted by:
Jack J. Dack, Chairman
National Association of
State Veterans Homes
Legislative Committee
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158

## NATIONAL ASSOCIATION OF STATE VETERANS HOMES

Mr. Chairman and Members of the Committee:

The National Association of State Veterans Homes appreciates the opportunity to express its views pertinent to the "Older Veterans Health Amendments and the Extension of the Authority of Certain Medical Programs".

We feel our involvement to be extremely important with the increasing demands being made upon our federal government for funding in taking care of our veterans, particularly those increasing numbers of elderly veterans who are reaching that time in life when the long-term health care delivery system will be stretched beyond capacity to partially meet this demand.

The State Veterans Home Program has grown from eleven homes in eleven states in 1888 to presently 53 homes in 35 states. Nursing home care is provided in 42 homes, domiciliary care in 46 homes, and hospital care in 7 homes. These homes presently have over 18,000 beds and, in FY 85, provided more than 4.6 million days of care (domiciliary 1,588,787; nursing home 2,863,430; hospital 182,076).

The program of assistance to states for construction, remodeling, and renovation of State Home facilities began on August 19, 1964, with the enactment of Public Law 88-450, which authorized annual appropriations of $5 million for making grants to State Homes by the Veterans Administration. These grants were limited to no more than 50% of the cost of constructing new nursing care facilities, expanding or remodeling buildings for use as nursing care facilities, and initially equipping such facilities. Not more than 10% of the funds appropriated for any fiscal year could be used to assist in construction of nursing home care facilities in any one state.

Since inception of the Construction Grant Program over 21 years ago, Public Laws 90-432, 93-82, and 97-251 have extended the program through 1986. Interspersed legislation, however, has significantly changed the program.

A. 1969, P.L. 91-178: Expanded grants to states for assistance in remodeling, modification, or alteration of existing hospital or domiciliary facilities in State Homes providing care and treatment to veterans.

B. 1973, P.L. 93-82: Changed the Veterans Administration participation rate from 50% to 65% and limited beds to two and one half per thousand veteran population of a state.

C. 1979, P.L. 85-62: Redefined construction to mean new domiciliary or nursing home buildings and expansion, remodeling, and alteration of existing buildings for the provision of domiciliary, nursing home care, or hospital care in State Homes and the provision of initial equipment for any such buildings. This Public Law changed the veteran occupancy requirement in State Homes receiving a construction grant from 90% to 75%. This act also changed the amount that any one state may receive in any fiscal year to one third of the amount appropriated in such fiscal year.

D. 1979, P.L. 96-151: Continued authorization of $15 million through 1980 and provided for such sums as were necessary for 1981 and 1982.

E. 1980, P.L. 96-330: Removed the legal limitation of two and a half beds per thousand veteran population in a state and left to the Administrator to prescribe the number of beds required to provide adequate nursing home care to veterans residing in each state. Regulations have established a ceiling of four beds per thousand veterans, with justification required if construction would result in nursing home beds in excess of two and a half beds per thousand veterans in each state.

F. 1984, P.L. 98-528: Expanded grants to states for acquisition of existing facilities to be used as State Homes as long as the cost plus renovation does not exceed the cost of the new construction.

G. 1985, P.L. 99-166: Deleted the deadline for availability of state construction funds and deferral of certain applications.

Since 1975, we have noted increased amounts of funding available, except for Fiscal Year 1980.

| Fiscal Year | Amount (thousands) |
|---|---|
| 1975 | 9,700 |
| 1976 | 10,000 |
| 1977 | 10,000 |
| 1978 | 15,000 |
| 1979 | 10,000 |
| 1980 | 7,500 |
| 1981 | 15,000 |
| 1982 | 15,840 |
| 1983 | 18,000 |
| 1984 | 18,000 |
| 1985 | 34,500 |
| 1986 | 20,822 (after 4.3% Gramm-Rudman reduction) |

It was in Fiscal Year 1975, following the increase in the percentage participation by the federal government in 1973, that interest by the states in the program seemed to grow. There is a backlog of applications at the federal level awaiting consideration for funding. (Exhibit A) As of February 28, 1986, eligible preapplications and applications involving 70 projects with an estimated grant request of $175,195,000 have been submitted.

Presently, there are 35 states with 50 veterans homes and three annexes. It is noted that twelve (12) states with veterans homes are establishing additional homes, which will provide an increase of 2,490 nursing and 350 domiciliary beds. Six (6) states with homes are increasing nursing care beds for an additional total of 527. Six (6) states have demonstrated interest in establishing veterans homes through discussion, preapplication, or application (Mississippi, Tennessee, Virginia, Alabama, Florida, and Kentucky). Nine (9) states at this time appear to have little/no interest in establishing a veterans home (Alaska, Arizona, Delaware, Hawaii, Nevada, North Carolina, Oregon, Texas, and Utah).

In general, the greatest interest in increased participation is in those states with existing homes where the state commitment to care for veterans has been accepted. In states without a veterans home, it may be five to fifteen years from the time a state first demonstrates interest until funding is provided for construction of a home.

A historic review of the program reveals that of the $189.9 million obligated from Fiscal Year 1966 through December 31, 1985, 136 projects out of an approved 179 have been completed. Expenditures of funds have resulted in 7,543 beds either through new construction or remodeling (50 projects--6,332 nursing care; 11 projects--1,211 domiciliary). One hundred eighteen (118) projects involve or have been involved with renovation for life safety, privacy, or to meet regulatory programmatic changes. The overall federal matching funds participation is 59.5% out of a maximum 65%. (Exhibits B and C)

The passage of legislation to extend the program, which the National Association of State Veterans Homes totally supports, is vital to the combined state and federal efforts focused on meeting the increasing needs of the nation's aging veteran population. While the total veteran population will get smaller from the present 27.8 million to 24.3 million in the year 2000, it will get older. The group of veterans at least 65 years of age, which now numbers close to 5 million, will grow to about 9 million. Veterans 65 and over will account for about 18% of the total veteran population. This proportion will rise steadily over the next three decades before peaking at 45% by the year 2015.

The Administration proposed shift to a 30% state-supported census will require additional State Veterans Home beds. These beds probably cannot be attained without continued support for increased appropriations for Grants for Construction of State Extended Care Facilities. In view of the current backlog depicted in Exhibit A and the lengthy time period for obtaining federal assistance, states are reluctant to establish or expand the program.

We in the Association are pleased with the recommended $42.4 million request in the Veterans Administration Fiscal Year 1987 Medical Care Budget for Grants for Construction of State Extended Care Facilities. This funding will assist in reducing the backlog of pending construction applications.

Increased funding for state construction projects will be a step in the right direction. However, again, with the recent shift in provider mix (state 20-30%, federal 40-30%, and community 40%), it is important that the per diem rates which are prescribed by law reflect the same consideration. Both sections of the program, construction and per diem, must walk hand in glove for the capacities to exist in the states to absorb the additional work load which will result both from the shifting of service from the Veterans Administration and from the aging of the veteran population in the states themselves. Appropriate levels of funding in both programs must be maintained to encourage those states currently providing veterans home services to retain and expand these services as well as to encourage additional states not currently providing state veterans homes to get into the program.

States expending efforts to assist in this problem, however, are becoming concerned over the increasing financial burden of such programs. The State Veterans Home Program has been determined to be a cost-effective alternative to providing long-term health care services in Veterans Administration facilities. Several state facilities are dealing with money freezes, budget cuts, and similar reduction measures reflecting fiscal problems being encountered by these states. It is noted that the operating expenditure of the State Veterans Home programs for Fiscal Year 1985 was an increase of approximately 6.5% over 1984. According to the Consumer Price Index, January, 1986, the national inflation rate in health care services was hovering around 6.9%, with an appearance, over time, of an upward spiral. Despite the past generosity of Congress, the per diem rates paid states continue to lag behind the accepted 30% federal proportionate share of funding. (Exhibit D)

## Veterans Administration Federal Grants Applicable to Domiciliary, Nursing, and Hospital Care Provided by State Veterans Homes

Cost Shared by Veterans Administration and Veterans Homes

FY 1984

| | Veterans Days of Care | Average Daily Census | Average Per Diem Cost | Total Veteran Cost | Grant in Aid by VA | Percent By VA |
|---|---|---|---|---|---|---|
| Domiciliary | 1,613,173 | 4,407.2 | $ 37.61 | $ 61,215,115 | $10,999,292 | 17.9% |
| Nursing | 2,752,816 | 7,491.1 | $ 60.84 | $173,539,868 | $39,215,861 | 22.5% |
| Hospital | 188,190 | 514.4 | $198.16 | $ 26,196,068 | $ 2,704,923 | 10.3% |
| | Overall Average | | $ 57.30 | | Overall Percent | 20.28% |
| | | | FY 1985 | | | |
| Domiciliary | 1,588,787 | 4,360 | $ 37.62 | $ 60,754,667 | $11,618,718 | 19.12% |
| Nursing | 2,863,430 | 7,883 | $ 65.39 | $129,530,055 | $48,759,404 | 25.33% |
| Hospital | [illegible]2,076 | 499 | $210.15 | $ 29,307,597 | $ 2,776,659 | 9.4% |
| | Overall Average | | $ 60.42 | | Overall Percent | 22.35% |

We in the Association are most concerned about maintaining the per diem rates at the 30% level for two reasons:

1. The care furnished by state veterans facilities is typically for severely disabled or impaired veterans who demonstrate a need to receive nursing care over a protracted period of time. This places the State Homes in the unique position of caring for severely debilitated patients requiring extensive amounts of care over a long-term period. This has become increasingly noticeable with the advent of the Diagnosis Related Groups (DRG) concept to providing care in community acute care facilities. This concept has been implemented in the Veterans Administration Medical Centers.

2. We feel continuation of the current per diem rates will be viewed as a further disincentive to both the full operation of existing State Home facilities and possible creation of additional beds to meet the demand of the aging World War II veteran.

Public Law 98-160 mandates that every three years the Veterans Administration shall submit a report to the Committees on Veteran Affairs of the Senate and House of Representatives on the adequacy of the per diem rates. The first report is to be submitted June 30, 1986. This report is to be based on the projections over each of the following five years of the demand on the Veterans Administration for the provision of nursing care to eligible veterans. With nursing home care services provided in state veterans homes being increased to 30%, apparently the demand for care has been determined by the administration. We would ask the Committees' continued support to maintain per diem rates at the 30% level.

We note with envy that the nursing care costs of the Veterans Administration and the community contract nursing home rates are adjusted annually as a part of the budget process. The per diem rates for the State Veterans Home Program are not, thus the need for us to come to the Congress to seek support for our request for rate enhancement.

Patient Obligation Data*

| Activity | 1985 Actual | 1986 Budget | 1986 Estimate | 1987 Estimate | Increase (+) Decrease (-) |
|---|---|---|---|---|---|
| Av. Obligation/Patient/Day: | | | | | |
| Medical Bed Section | $308.75 | $308.06 | $324.54 | $335.24 | +$10.70 |
| Intermediate Bed Section | $135.32 | $139.08 | $141.02 | $145.09 | +$ 4.07 |
| VA Nursing Homes | $111.94 | $114.02 | $113.84 | $120.04 | +$ 6.20 |
| VA Domiciliaries | $ 43.62 | $ 45.45 | $ 44.70 | $ 46.11 | +$ 1.41 |
| Community Nursing Homes | $ 59.87 | $ 66.69 | $ 64.38 | $ 69.53 | +$ 5.15 |
| State Home Domiciliaries | $ 7.30 | $ 7.30 | $ 7.30 | $ 7.30 | --- |
| State Home Nursing | $ 17.05 | $ 17.05 | $ 17.05 | $ 17.05 | --- |
| State Home Hospital | $ 15.25 | $ 15.25 | $ 15.25 | $ 15.25 | --- |

*Medical Programs, Fiscal Year 1987, Volume 11, Office of Budget and Finance (Controller), February, 1986, Washington, D.C.

The National Association of State Veterans Homes has developed and submitted to both the Senate and House Veteran Affairs Committees a proposal and rationale for an increase in per diem payments for State Veterans Homes maintaining the tradition that Congress has held that the rates should be at the 30% level. (Exhibit E) Again we would ask your support of this request.

With the shift in the provider mix of health care services for Veterans Administration sponsored programs in long-term care for veterans, the federal government is turning more to the states to provide for those who have served. What better way to provide the quality of care they deserve than being cared for in a State Veterans Home? The services provided by the State Veterans Homes reflect a sensitivity and an acknowledgement of the contribution made by its patients. In addition, it is cost-effective and high quality.

Mr. Chairman, we in the National Association of State Veterans Homes understand that there is a legislative proposal by the Veterans Administration to discontinue the Office for Geriatrics and Extended Care as presently established. We understand there would be a complete shift of the long-term care programs to an Office of Clinical Affairs which is currently acute care oriented. The members of the National Association of State Veterans Homes is opposed to such a move. The present Office of Assistant Chief Medical Director for Geriatrics and Extended Care in which the State Veterans Home Program is located serves the [illegible] homes and 35 states very well. It can be viewed as a "one-stop shopping center". We work closely with Dr. John H. Mather, Mr. Brent Baker, and Ms. Marsha Goodwin of that office in regards to the overall State Veterans Home programming. We are not lost in a maze or referred to and from and back again to receive a response to a concern or question regarding the State Home Program. In most cases, a prompt response is received. The staff is most professional, dedicated, concerned, and helpful. It, indeed, would be a tremendous loss to have the State Home Program integrated and buried within an acute care area of responsibility. The Association feels the interest generated in long-term care programming would be lost to acute care concerns and initiatives. In addition, we feel the close working relationship now existing between the participating states, interested states, and the Veterans Administration could be destroyed.

This close working relationship between the National Association of State Veterans Homes and the Veterans Administration was formalized on February 24, 1986, with the signing of a "Memorandum of Understanding". (Exhibit F) This was to formalize the long-standing efforts of the National Association of State Veterans Homes and the Veterans Administration through the Office for Geriatrics and Extended Care to provide quality care to veterans. Both organizations agreed to work together to identify areas for enhancing the quality of care for veterans through an exchange of information. Areas of focus include the establishment, expansion, and renovation of State Veterans Homes and the results of research by the Veterans Administration, State Homes, the National Association of State Veterans Homes, and the agencies or individuals pertinent to long-term care and the elderly.

Representatives from the Veterans Administration and the National Association of State Veterans Homes will meet on a regular basis to develop strategies and target dates for implementing goals regarding long-term care programming.

Credit must be given to Dr. Mather, Assistant Chief Medical Director for Geriatrics and Extended Care, and his State Home Program staff for their dedication to task, cooperativeness, and continuing interest in the State Veterans Home Program. We in the Association would not want to lose this federal and state impetus in the area of long-term health care planning.

While the Congress of the United States has been most generous in providing for its veterans, and the Veterans Administration has done an outstanding job within the confines of budgeting limitations in taking care of our veterans, the resources to do so are becoming limited. We must work closer together, share ideas, stretch and share resources, and assist one another if we are going to fulfill our mutual obligation.

The nation's commitment to take care of its veterans must be met. There is nothing illogical in sharing this burden with the states.

Thank you.

Jack J. Dack

Jack J. Dack, Chairman
National Association of
State Veterans Homes
Legislative Committee
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158

EXHIBIT A

## Eligible Preapplications and Applications for Grants for Construction of State Extended Care Facilities

(pending approval - dollars in thousands)

2/28/86

| FAI No. | State (locality) | Project | Estimated Grant Request |
|---|---|---|---|
| 24-003 | MD (Charlotte Hall) | (3rd Phase - 126 Dom/NH Beds) | 3,047 |
| 24-004 | MD (Charlotte Hall) | (4th Phase - 126 Dom/NH Beds) | 5,298 |
| 17-007 | IL (Quincy) | Renovation Andrew | 351 |
| 17-008 | IL (Quincy) | Energy Conservation | 117 |
| 06-014 | CA (Yountville) | Rem. Sec. D Dom-Life Safety | 2,117 |
| 34-010 | NJ (Paramus Phase II A) | New State Home - 240 Bed NH | 11,644 |
| 28-001 | MS (Jackson) | New State Home - 150 Bed NH | 4,388 |
| 30-002 | MT (Columbia Falls) | 50 Bed NH Wing | 1,203 |
| 25-029 | MA (Chelsea) | Elevators | 78 |
| 25-030 | MA (Chelsea) | Renovations | 76 |
| 06-012 | CA (Yountville) | Remodel Hospital Ward 1A | 118 |
| 37-N003 | PA (Hollidaysburg) | Renovations-NHC-Grant Increase | 99 |
| 37-N004 | PA (Hollidaysburg) | Renovations-Dom-Grant Increase | 191 |
| 13-004 | GA (Milledgeville) | 150 Bed NH | 4,550 |
| 27-006 | MN (Hastings) | Grant Increase | 474 |
| 17-010 | IL (Quincy) | Life Safety - Fire Alarm | 144 |
| 42-009 | PA (Hollidaysburg) | Renovate Dietary Building | 1,800 |
| 06-013 | CA (Yountville) | Rem. Sec. B to Dom Life Safety | 2,179 |
| 06-011 | CA (Yountville) | Cooling Plant and Piping | 1,359 |
| 06-015 | CA (Yountville) | Rem. Sec. E Life Safety | 1,729 |
| 06-016 | CA (Yountville) | Rem. Hospital Support Service | 1,300 |
| 06-017 | CA (Yountville) | Rem. Nursing Home 1-3 AB | 1,557 |
| 06-018 | CA (Yountville) | Rem. Sec. F - Handicapped | 1,299 |
| 06-019 | CA (Yountville) | Rem. Workshop - Sprinkler | 98 |
| 36-002 | NY (Long Island) | New 350 Bed NH | 14,780 |
| 06-020 | CA (Yountville) | Rem. Sec. H Dom-Fire & Safety | 1,105 |
| 06-021 | CA (Yountville) | Rem. Sec. J Dom-Fire & Safety | 1,105 |
| 06-022 | CA (Yountville) | Rem. Sec. K Dom-Fire & Safety | 1,105 |
| 06-023 | CA (Yountville) | Rem. Sec. L Dom-Fire & Safety | 1,105 |
| 06-024 | CA (Yountville) | Rem. NHC Wings 1-3C-D | 1,557 |
| 05-002 | AR (Little Rock) | Conversion 70 Dom Beds to NH | 195 |
| 42-008 | PA (Hollidaysburg) | Renovation-Sommer-225 NH Beds | 4,091 |
| 44-003 | RI (Bristol) | Domiciliary Renovation | 1,138 |
| 12-001 | FL (Lake City) | New State Home 150 Bed Dom | 2,730 |
| 39-002 | OH (Sandusky) | Grant Increase NHC | 221 |
| 29-004 | MO (St. James) | Replace NHC Unit (+50 Beds) | 2,420 |
| 40-009 | OK (Clinton) | Replace NHC Unit | 965 |
| 16-002 | ID (Boise) | Renovate Dom/NHC Beds | 1,105 |
| 39-009 | OH (Sandusky) | Power Plant | 1,409 |
| 06-025 | CA (Yountville) | Remodel NHC Wards 2-3 E | 813 |
| 06-026 | CA (Yountville) | Remodel Annex I NHC | 1,170 |
| 06-027 | CA (Yountville) | Remodel Annex II NHC | 1,170 |
| 06-034 | CA (Yountville) | Remodel Ground & 1st Fl. Hosp. | 650 |
| 06-028 | CA (Yountville) | Remodel Dom Sec. G & LSC | 1,463 |
| 54-003 | WV (Pruntytown Phs. I) | Remodel School for 202 NHC | 2,961 |
| 54-004 | WV (Pruntytown Phs. II) | Remodel School for 94 Bed Dom | 2,602 |

EXHIBIT A

| FAI No. | State (locality) | Project | Estimated Grant Request |
|---|---|---|---|
| 06-031 | CA (Yountville) | Renovate Kitchen & Dining Room | 195 |
| 06-032 | CA (Yountville) | Renovate Hospital Food Service | 195 |
| 06-029 | CA (Yountville) | Renovations - Storage Areas | 195 |
| 06-033 | CA (Yountville) | Renovations - Sprinkler System | 98 |
| 06-035 | CA (Yountville) | Renovations - Admin. Building | 98 |
| 39-003 | OH (Sandusky) | New 300 Bed Dom Replacement | 9,223 |
| 39-010 | OH (Sandusky) | New 200 Bed Dom Replacement | 5,188 |
| 01-001 | AL (Alexander City) | New 150 Bed NHC | 4,615 |
| 29-005 | MO (SE) | New 150 Bed NHC | 5,850 |
| 29-006 | MO (NW) | New 150 Bed NHC | 5,850 |
| 39-011 | OH (Sandusky) | Add 100 NHC Beds, Secrest | 2,918 |
| 40-010 | OK (Claremore) | New 250 Bed NHC | 8,450 |
| 42-010 | PA (Pennhurst Phase I) | Renov. for 180 NHC; 150 Dom | 4,011 |
| 42-011 | PA (Pennhurst Phase II) | Construct 270 NHC Beds | 7,670 |
| 45-002 | SC (Anderson) | New 220 Bed NHC | 5,850 |
| 55-011 | WI (King) | Renovate NHC Unit | 3,187 |
| 16-003 | ID (Eastern ID) | New 22 Dom/60 NHC | 2,979 |
| 19-026 | IA (Clarinda) | Remodel for 68 NHC | 2,118 |
| 19-027 | IA (Marshalltown) | Dietary Facility | 1,841 |
| 23-002 | ME (Biddeford) | New 120 NHC | 4,875 |
| 26-004 | MI (Macomb) | New 170 NHC/84 Dom | 3,307 |
| 40-011 | OK (Talihina) | NHC Addition +51 Beds | 1,999 |
| 40-012 | OK (Clinton) | Dining/Kitchen Facility | 1,034 |
| 42-012 | PA (Pennhurst) | Dietary Facility | 2,373 |
| | | | 175,195 |

| Summary (as of February 28, 1986) | |
|---|---|
| Funds Available from FY 86 | 20,822 |
| Funds Available from FY 85 | 15,537 |
| Funds Available from FY 84 | 3,047 |
| | 39,406 |
| Projects eligible for which funds are not available | 135,789 |

Remarks:

1. 34-010 NH (Paramus) Phase II & III combined as Phase II Amended with estimate from $10,185 to $11,644.

2. 24-003 MD (Charlotte Hall) deobligated '84 funds for Phase III: $3,047,179.

Office of Extended Care (182C)
Department of Medicine & Surgery
Veterans Administration
Washington, D.C.

STATUS OF GRANTS FOR CONSTRUCTION OF STATE HOMES

COB 12/31/85

EXHIBIT B

| Appropriation 36-/-0181.40 | Appropriated Amount | Apportionment | Unapportioned | Obligated | Unobligated Balance |
|---|---|---|---|---|---|
| FY 1966 - 1983 | 151,040,000 | 151,040,000 | 0 | 148,990,027 | 2,049,973 |
| FY 1984(Exp.9/30/86) | 18,000,000 | 18,000,000 | 0 | 18,000,000 | 0 |
| FY 1985(Exp.9/30/87) | 34,500,000 | 34,500,000 | 0 | 18,962,783 | 15,537,217 |
| FY 1986(Exp.9/30/88) | 21,758,000 | 21,758,000 | 0 | 0 | 21,758,000 |
| GRAND TOTAL | 225,298,000 | 225,298,000 | 0 | 185,952,810 | 39,345,190 |

| Project Number | Location | Number of Beds | Total Est. Cost | Oblig. Chngs During Month | VA Funds Obligated |
|---|---|---|---|---|---|
| 05-001 | AR,LITTLE ROCK | 150 D | 1,912,416 | | 1,243,071 * |
| 04-N001 | CA,YOUNTVILLE | | 66,803 | | 43,422 * |
| 04-N002 | CA,YOUNTVILLE | | 288,529 | | 187,544 * |
| 04-N003 | CA,YOUNTVILLE | | 101,362 | | 65,885 * |
| 04-N004 | CA,YOUNTVILLE | | 435,512 | | 283,083 * |
| 04-N005 | CA,YOUNTVILLE | | 829,924 | | 529,268 * |
| 04-N006 | CA,YOUNTVILLE | | 63,900 | | 41,535 * |
| 04-N007 | CA,YOUNTVILLE | | 133,806 | | 86,974 * |
| 06-008 | CA,YOUNTVILLE | | 11,428,657 | | 7,428,627 |
| 06-009 | CA,YOUNTVILLE | | 4,237,750 | | 2,754,537 |
| 06-010 | CA,YOUNTVILLE | | 3,156,450 | | 2,051,692 |
| 05-N004 | CO,FLORENCE | 120 N | 1,331,310 | | 848,164 * |
| 05-N001 | CO,HOMELAKE | | 30,727 | | 19,399 * |
| 05-N002 | CO,HOMELAKE | | 122,908 | | 79,890 * |
| 05-N003 | CO,HOMELAKE | | 200,000 | | 127,981 * |
| 05-N005 | CO,HOMELAKE | | 133,557 | | 86,794 * |
| 08-006 | CO,HOMELAKE | | 436,467 | | 283,687 * |
| 08-007 | CO,RIFLE | 100 N | 3,571,428 | 2,321,428 | 2,321,428 |
| 06-N001 | CT,ROCKY HILL | | 171,675 | | 107,859 * |
| 06-N002 | CT,ROCKY HILL | | 131,159 | | 85,253 * |
| 09-N003 | CT,ROCKY HILL | | 181,408 | | 109,398 * |
| 09-004 | CT,ROCKY HILL | | 1,038,581 | | 533,827 * |
| 09-005 | CT,ROCKY HILL | | 247,875 | | 150,339 |
| 09-006 | CT,ROCKY HILL | | 275,500 | | 168,756 |
| 09-007 | CT,ROCKY HILL | | 341,395 | | 181,431 |
| 09-008 | CT,ROCKY HILL | | 508,181 | | 330,317 |
| 10-N001 | GA,AUGUSTA | 192 N | 1,956,000 | | 977,857 * |
| 10-N002 | GA,MILLEDGEVILLE | 132 N | 1,718,599 | | 859,299 * |
| 10-N003 | GA,MILLEDGEVILLE | | 4,130,231 | | 1,766,409 * |
| 14-N001 | IA,MARSHALLTOWN | 80 N | 1,063,826 | | 527,822 * |
| 14-N002 | IA,MARSHALLTOWN | | 205,324 | | 102,305 * |
| 14-N003 | IA,MARSHALLTOWN | | 73,278 | | 36,638 * |
| 14-N004 | IA,MARSHALLTOWN | | 10,842 | | 5,421 * |
| 14-N005 | IA,MARSHALLTOWN | | 40,450 | | 17,253 * |
| 14-N006 | IA,MARSHALLTOWN | | 4,822 | | 2,233 * |
| 14-N007 | IA,MARSHALLTOWN | | 2,266 | | 1,079 * |
| 14-N008 | IA,MARSHALLTOWN | | 9,644 | | 4,509 * |
| 14-N009 | IA,MARSHALLTOWN | | 1,560 | | 1,094 * |
| 14-N010 | IA,MARSHALLTOWN | | 14,820 | | 7,401 * |

*Completed Projects

D = DOM
N = Nursing Home

EXHIBIT B

| Project Number | Location | Number of Beds | Total Est. Cost | Oblig.Chngs During Month | VA Funds Obligated |
|---|---|---|---|---|---|
| 14-N016 | IA,MARSHALLTOWN | | 3,960 | | 1,745 * |
| 14-N017 | IA,MARSHALLTOWN | | 10,194 | | 4,356 * |
| 14-N020 | IA,MARSHALLTOWN | 360 N | 12,622,882 | | 7,875,314 * |
| 14-N021 | IA,MARSHALLTOWN | | 148,922 | | 94,110 * |
| 14-N022 | IA,MARSHALLTOWN | | 1,845,985 | | 1,259,758 * |
| 14-N023 | IA,MARSHALLTOWN | 180 N | 7,767,876 | | 4,947,331 * |
| 19-024 | IA,MARSHALLTOWN | | 2,194,000 | | 1,568,000 * |
| 19-025 | IA,MARSHALLTOWN | | 589,948 | | 383,467 |
| 16-001 | ID,BOISE | 90 (BON,10D) | 2,222,807 | | 1,367,851 * |
| 17-005 | IL,MANTENO | 300 N | 18,093,876 | | 11,761,020 |
| 12-N001 | IL,QUINCY | 200 N | 2,882,000 | | 1,374,731 * |
| 17-002/3 | IL,QUINCY | | 518,518 | | 409,872 * |
| 17-004 | IL,QUINCY | | 222,840 | | 144,846 |
| 17-009 | IL,QUINCY | | 500,000 | | 325,000 |
| 13-N001 | IN,LAFAYETTE | 100 N | 5,640,262 | | 2,799,138 * |
| 13-N002 | IN,LAFAYETTE | 150 N | 6,891,985 | | 3,326,531 * |
| 15-N001 | KS,FT.DODGE | 88 N | 830,000 | | 414,563 * |
| 22-001 | LA,JACKSON | 235 (35N,200D) | 8,675,000 | | 5,000,000 * |
| 20-N002 | MA,CHELSEA | | 44,000 | | 22,000 * |
| 20-N003 | MA,CHELSEA | | 7,500 | | 3,750 * |
| 20-N004 | MA,CHELSEA | | 19,500 | | 9,750 * |
| 20-N005 | MA,CHELSEA | | 21,000 | | 10,500 * |
| 20-N006 | MA,CHELSEA | | 10,830 | | 5,415 * |
| 20-N007 | MA,CHELSEA | | 6,750 | | 3,375 * |
| 20-N008 | MA,CHELSEA | | 2,858,962 | | 1,564,038 * |
| 20-N019 | MA,CHELSEA | | 581,000 | | 366,114 * |
| 20-N020 | MA,CHELSEA | | 1,111,770 | | 505,434 * |
| 20-N021 | MA,CHELSEA | | 138,037 | | 70,205 * |
| 20-N022 | MA,CHELSEA | | 54,594 | | 28,820 * |
| 20-N023 | MA,CHELSEA | | 12,000 | | 7,872 * |
| 20-N025 | MA,CHELSEA | | 75,808 | | 46,161 * |
| 25-027 | MA,CHELSEA | | 127,857 | | 80,430 * |
| 25-028 | MA,CHELSEA | | 90,300 | | 38,020 * |
| 20-N001 | MA,HOLYOKE | 155 N | 1,898,000 | | 735,716 * |
| 20-N010 | MA,HOLYOKE | | 513,390 | | 304,397 *1/ |
| 20-N011 | MA,HOLYOKE | | 342,260 | | 222,469 |
| 20-N012 | MA,HOLYOKE | | 7,770 | | 5,050 |
| 20-N013 | MA,HOLYOKE | | 3,330 | | 2,165 |
| 20-N014 | MA,HOLYOKE | | 11,100 | | 7,215 |
| 20-N015 | MA,HOLYOKE | | 33,300 | | 21,645 |
| 20-N016 | MA,HOLYOKE | | 18,870 | | 12,265 |
| 20-N017 | MA,HOLYOKE | | 11,988 | | 7,792 |
| 20-N018 | MA,HOLYOKE | | 8,722 | | 5,670 |
| 23- 001 | ME,AUGUSTA | 120 N | 4,472,000 | | 2,906,800 |
| 24- 001 | MD,CHARLOTTE HALL | 126 D | 9,455,000 | | 5,909,687 |
| 24- 002 | MD,CHARLOTTE HALL | 126 D | 5,225,897 | | 3,266,186 |
| 24- 003 | MD,CHARLOTTE HALL | 126 D | 4,875,486 | | 3,047,179 |
| 21-N001 | MI,GRAND RAPIDS | 537 N | 7,688,568 | | 3,702,005 * |
| 26-002 | MI,GRAND RAPIDS | | 14,065,100 | | 9,142,315 |
| 26-003 | MI,MARQUETTE | | 4,289,291 | | 2,788,039 |
| 27- 006 | MN,HASTINGS | | 1,968,700 | | 1,279,330 |
| 22-N001 | MN,MINNEAPOLIS | 250 N | 9,035,365 | | 5,867,715 |
| 22-N002 | MN,MINNEAPOLIS | | 76,799 | | 49,919 * |
| 22-N003 | MN,MINNEAPOLIS | | 51,188 | | 33,272 * |
| 22-N004 | MN,MINNEAPOLIS | | 250,000 | | 162,282 * |
| 22-N005 | MN,MINNEAPOLIS | | 100,000 | | 65,218 * |

*Completed Projects

D = DOM
N = Nursing Home

1/Holyoke Total 10/18 = $617,975

EXHIBIT B

| Project Number | Location | Number of Beds | Total Est. Cost | Oblig. Changes During Month | VA Funds Obligated |
|---|---|---|---|---|---|
| 24-N001 | MO,ST. JAMES | 60 N | 966,100 | | 483,019 * |
| 29- 002 | MO,ST. JAMES | | 603,122 | | 365,370 |
| 29- 003 | MO,MEXICO | 150 N | 6,335,791 | | 4,104,959 |
| 25-N001 | MT,COLUMBIA FALLS | 40 N | 448,685 | | 219,783 * |
| 26-N001 | NB,GRAND ISLAND | 100 N | 2,043,737 | | 743,723 * |
| 26-N002 | NB,GRAND ISLAND | 100 N | 1,141,415 | | 533,470 * |
| 26-N003 | NB,GRAND ISLAND | | 114,306 | | 55,385 * |
| 26-N004 | NB,SCOTTS BLUFF | | 617,855 | | 401,606 * |
| 31- 005 | NB,SCOTTS BLUFF | 50 N | 2,075,630 | | 1,349,160 |
| 33-N001 | ND,LISBON | | 54,235 | | 35,117 * |
| 33-N002 | ND,LISBON | | 1,727,161 | | 1,122,655 |
| 28-N001 | NH,TILTON | 50 N | 748,000 | | 373,583 * |
| 28-N002 | NH,TILTON | 50 N | 1,768,054 | | 1,111,363 * |
| 29-N002 | NJ,MENLO PARK | 100 N | 1,925,000 | | 943,374 * |
| 29-N004 | NJ,MENLO PARK | 100 N | 1,766,873 | | 867,211 * |
| 29-N007 | NJ,MENLO PARK | | 347,147 | | 138,866 * |
| 34-008 | NJ,MENLO PARK | | 1,148,165 | | 746,307 * |
| 34-009 | NJ,PARAMUS | 114N | 9,715,358 | | 5,926,368 |
| 29-N001 | NJ,VINELAND | 100 N | 1,296,801 | | 559,808 * |
| 29-N003 | NJ,VINELAND | 100 N | 2,846,241 | | 967,064 * |
| 29-N005 | NJ,VINELAND | 100 N | 3,544,819 | | 1,463,987 * |
| 34-N006 | NJ,VINELAND | | 433,293 | | 288,140 * |
| 35-002 | NM,TRUTH/CONSEQ | | 5,400,000 | | 3,475,980 |
| 34-N001 | OH,SANDUSKY | 300 N | 9,795,489 | | 6,179,386 * |
| 39-002 | OH,SANDUSKY | | 7,879,500 | | 5,109,856 |
| 35-N005 | OK,ARDMORE | | 47,912 | | 31,143 * |
| 40-008 | OK,ARDMORE | 100 N | 2,247,083 | | 1,460,604 * |
| 35-N002 | OK,CLINTON | | 135,000 | | 66,528 * |
| 35-N004 | OK,CLINTON | 36 N | 499,943 | | 324,962 * |
| 35-N007 | OK,CLINTON | | 122,760 | | 79,794 * |
| 35-N001 | OK,NORMAN | 50 N | 459,514 | | 229,757 * |
| 35-N003 | OK,NORMAN | | 32,682 | | 15,806 * |
| 35-N006 | OK,SULFUR | | 106,877 | | 69,470 * |
| 37-N001 | PA,ERIE | | 739,126 | | 264,210 * |
| 37-N002 | PA,ERIE | 75 N | 2,322,091 | | 1,458,317 * |
| 37-N005 | PA,ERIE | | 175,000 | | 138,294 * |
| 42-007 | PA,ERIE | | 1,776,846 | | 487,692 |
| 37-N003 | PA,HOLLIDAYSBURG | 200 N | 3,147,988 | | 2,212,721 |
| 37-N004 | PA,HOLLIDAYSBURG | 212 D | 2,890,258 | | 1,582,666 |
| 42-006 | PA,HOLLIDAYSBURG | | 951,130 | | 618,235 |
| 38-N001 | RI,BRISTOL | 165 N | 705,838 | | 352,919 * |
| 38-N002 | RI,BRISTOL | 150 N | 3,905,342 | | 2,538,472 * |
| 39-N001 | SC,COLUMBIA | 115 N | 1,982,000 | | 687,174 * |
| 40-N001 | SD,HOT SPRINGS | | 42,186 | | 27,364 * |
| 46-008 | SD,HOT SPRINGS | | 29,872 | | 19,370 * |
| 44-N001 | VT,BENNINGTON | 22 N | 251,939 | | 122,461 * |
| 44-N002 | VT,BENNINGTON | 40 N | 1,284,680 | | 437,301 * |
| 44-N003 | VT,BENNINGTON | | 61,650 | | 30,825 * |
| 44-N004 | VT,BENNINGTON | 73 N | 3,650,422 | | 2,075,836 * |
| 44-N005 | VT,BENNINGTON | | 341,139 | | 221,740 * |
| 50-006 | VT,BENNINGTON | 50 N | 6,146,600 | | 3,995,290 |

*Completed Projects

D = DOM
N = Nursing Home

EXHIBIT B

| Project Number | Location | Number of Beds | Total Est. Cost | Oblig. Changes During Month | VA Funds Obligated |
|---|---|---|---|---|---|
| 46-N001 | WA,ORTING | | 25,319 | | 7,373 * |
| 46-N002 | WA,ORTING | | 50,784 | | 11,377 * |
| 46-N003 | WA,ORTING | | 256,776 | | 166,905 * |
| 46-N004 | WA,ORTING | | 161,619 | | 105,052 * |
| 46-N005 | WA,ORTING | | 66,359 | | 43,133 * |
| 46-N006 | WA,ORTING | | 30,968 | | 20,129 * |
| 46-N007 | WA,ORTING | | 243,692 | | 158,400 * |
| 46-N008 | WA,ORTING | | 365,540 | | 237,602 * |
| 46-N015 | WA,ORTING | 40 N | 1,793,823 | | 1,143,138 * |
| 46-N016 | WA,ORTING | | 631,780 | | 410,657 * |
| 46-N017 | WA,ORTING | | 755,793 | | 500,851 * |
| 46-N009 | WA,RETSIL | | 220,011 | | 143,007 * |
| 46-N010 | WA,RETSIL | | 330,017 | | 214,511 * |
| 46-N011 | WA,RETSIL | 78 N | 2,633,863 | | 1,692,784 * |
| 46-N012 | WA,RETSIL | | 1,144,749 | | 744,087 * |
| 46-N013 | WA,RETSIL | | 272,681 | | 177,243 * |
| 46-N014 | WA,RETSIL | | 409,022 | | 265,864 * |
| 46-N018 | WA,RETSIL | | 135,342 | | 87,972 * |
| 46-N019 | WA,RETSIL | | 90,288 | | 57,311 * |
| 48-N001 | WI,KING | 200 N | 2,867,697 | | 1,164,131 * |
| 48-N002 | WI,KING | 200 N | 3,223,000 | | 1,479,202 * |
| 48-N003 | WI,KING | | 95,130 | | 47,565 * |
| 48-N004 | WI,KING | | 44,768 | | 22,084 * |
| 48-N005 | WI,KING | | 105,428 | | 45,410 * |
| 48-N006 | WI,KING | | 150,000 | | 73,240 * |
| 48-N007 | WI,KING | | 311,330 | | 200,846 * |
| 48-N008 | WI,KING | | 350,160 | | 226,089 * |
| 48-N009 | WI,KING | | 116,721 | | 75,869 * |
| 55-010 | WI,KING | 45 N | 7,720,000 | | 5,018,000 |
| 13-N001 | WY,BUFFALO | | 386,000 | | 250,900 * |
| 56-002 | WY,BUFFALO | 60 D | 2,805,000 | | 1,716,000 * |
| 54-001 | WV,BARBOURSVILLE | 47 D | 2,141,538 | | 1,392,000 |
| 54-002 | WV,BARBOURSVILLE | 154 D | 1,917,998 | | 1,116,258 |
| GRAND TOTALS | | 7543 | 312,493,880 | 2,321,428 | 185,952,810 |

*Completed Projects

D = DOM
N = Nursing Home

Office of Extended Care (182C)
Department of Medicine & Surgery
Veterans Administration
Washington, D.C.

EXHIBIT C

## STATUS OF GRANTS FOR CONSTRUCTION OF STATE HOMES
## SUMMARY

| STATE | NUMBER OF BEDS DORM | NUMBER OF BEDS NURSING | TOTAL ESTIMATED COST | V.A. FUNDS OBLIGATED | NUMBER OF PROJECTS | NUMBER OF PROJECTS COMPLETED |
|---|---|---|---|---|---|---|
| AR | 150 | | 1,912,416 | 1,243,071 | 1 | 1 |
| CA | | | 20,742,693 | 13,472,567 | 10 | 7 |
| CO | | 220 | 5,826,397 | 3,767,343 | 7 | 6 |
| CT | | | 2,895,774 | 1,667,180 | 8 | 4 |
| GA | | 324 | 7,804,830 | 3,603,565 | 3 | 3 |
| IA | | 620 | 26,610,599 | 16,839,836 | 18 | 17 |
| ID | 10 | 80 | 2,222,807 | 1,367,851 | 1 | 1 |
| IL | | 500 | 22,217,234 | 14,015,469 | 5 | 2 |
| IN | | 250 | 12,532,247 | 6,125,669 | 2 | 2 |
| KS | | 88 | 830,000 | 414,563 | 1 | 1 |
| LA | 200 | 35 | 8,675,000 | 5,000,000 | 1 | 1 |
| MA | | 155 | 8,008,638 | 4,086,268 | 25 | 17 |
| ME | | 120 | 4,472,000 | 2,906,800 | 1 | 0 |
| MD | 378 | | 19,556,383 | 12,223,052 | 3 | 0 |
| MI | | 537 | 26,042,959 | 15,632,359 | 3 | 1 |
| MN | | 250 | 11,482,052 | 7,457,736 | 6 | 4 |
| MO | | 210 | 7,905,013 | 4,953,348 | 3 | 1 |
| MT | | 40 | 448,685 | 219,783 | 1 | 1 |
| NB | | 250 | 5,992,943 | 3,083,344 | 5 | 4 |
| ND | | | 1,781,396 | 1,157,772 | 2 | 1 |
| NH | | 100 | 2,516,054 | 1,484,946 | 2 | 2 |
| NJ | | 614 | 23,033,697 | 11,901,125 | 9 | 8 |
| NM | | | 5,400,000 | 3,475,980 | 1 | 0 |
| OH | | 300 | 17,674,989 | 11,289,242 | 2 | 1 |
| OK | | 186 | 3,651,771 | 2,278,064 | 8 | 8 |
| PA | 212 | 275 | 12,002,439 | 6,762,135 | 7 | 3 |
| RI | | 315 | 4,611,180 | 2,891,391 | 2 | 2 |
| SC | | 115 | 1,982,000 | 687,174 | 1 | 1 |
| SD | | | 72,058 | 46,734 | 2 | 2 |
| VT | | 185 | 11,736,430 | 6,883,453 | 6 | 5 |
| WA | | 118 | 9,618,426 | 6,187,396 | 19 | 19 |
| WI | | 445 | 14,984,234 | 8,352,436 | 10 | 9 |
| WY | 60 | | 3,191,000 | 1,966,900 | 2 | 2 |
| WV | 201 | | 4,059,536 | 2,508,258 | 2 | 0 |
| TOTAL | 1,211 | 6,332 | 312,493,880 | 185,952,810 | 179 | 136 |
| | 7543 | | | | | |

| Appropriation 36-/-0181.40 | Appropriated Amount | Apportionment | Unappor-tioned | Obligated | Unobligated Balance |
|---|---|---|---|---|---|
| FY 1966 - 1983 | 151,040,000 | 151,040,000 | 0 | 148,990,027 | 2,049,973 |
| FY 1984 (Exp. 9/30/86) | 18,000,000 | 18,000,000 | 0 | 18,000,000 | 0 |
| FY 1985 (Exp. 9/30/87) | 34,500,000 | 34,500,000 | 0 | 18,962,783 | 15,537,217 |
| FY 1986 (Exp. 9/30/88) | 21,758,000 | 21,758,000 | 0 | 0 | 21,758,000 |
| GRAND TOTAL | 225,298,000 | 225,298,000 | 0 | 185,952,810 | 39,345,190 |

bg/02-03-86

EXHIBIT D

## VA FEDERAL GRANTS APPLICABLE TO DOMICILIARY, NURSING, AND HOSPITAL CARE PROVIDED BY STATE HOMES

FY 1985

DOMICILIARY CARE 39 WITH 3 ANNEXES

COST SHARED BY VETERANS ADMINISTRATION & VETERANS HOME

| | | VETERAN DAYS OF CARE | AVERAGE DAILY CENSUS | AVERAGE PER DIEM COST | TOTAL VETERAN COST | GRANT-IN-AID BY VA | PERCENT OF COST |
|---|---|---|---|---|---|---|---|
| | Summary | 1,588,787 | 4,360 | $37.62 | $60,754,667.60 | $11,618,778.00 | 19.12% |
| AR | Little Rock | 35,130 | 96.1 | 27.91 | 980,473.00 | 256,084.00 | 26.12% |
| CA | Yountville | 231,255 | 633.5 | 50.28 | 11,627,501.40 | 1,688,161.50 | 14.52% |
| CO | Homelake | 26,952 | 73.8 | 23.92 | 644,691.80 | 197,012.40 | 30.56% |
| CT | Rocky Hill | 125,784 | 344.7 | 24.00 | 3,018,816.00 | 918,223.20 | 30.42% |
| GA | Milledgeville | 64,741 | 177.4 | 60.11 | 3,891,581.50 | 472,609.30 | 12.14% |
| ID | Boise | 32,877 | 89.3 | 25.21 | 828,829.20 | 239,982.10 | 28.95% |
| IL | Quincy | 35,550 | 97.4 | 42.54 | 1,512,297.00 | 259,515.00 | 17.16% |
| IN | Lafayette | 34,896 | 95.3 | 45.57 | 1,590,210.70 | 254,740.80 | 16.02% |
| IA | Marshalltown | 36,216 | 92.2 | 36.95 | 1,338,181.20 | 264,376.80 | 19.76% |
| KS | Fort Dodge | 24,556 | 67.3 | 27.91 | 685,357.90 | 179,258.80 | 26.16% |
| LA | Jackson | 25,857 | 70.8 | 43.14 | 1,115,470.90 | 188,756.10 | 16.92% |
| MD | Charlotte Hall* | 4,540 | 27.5 | 25.30 | 114,862.00 | 33,142.00 | 28.85% |
| MA | Chelsea | 97,743 | 267.8 | 21.92 | 2,142,526.50 | 713,523.90 | 33.30% |
| MA | Holyoke | 12,948 | 35.5 | 24.39 | 315,801.70 | 94,520.40 | 29.93% |
| MI | Grand Rapids | 53,559 | 146.9 | 27.01 | 1,446,628.60 | 390,980.70 | 27.03% |
| MI | Marquette | 26,230 | 71.9 | 61.41 | 1,610,784.30 | 191,479.00 | 11.89% |
| MN | Hastings | 64,754 | 177.4 | 29.45 | 1,907,005.30 | 472,704.20 | 24.79% |
| MN | Minneapolis | 66,227 | 181.4 | 24.92 | 1,650,376.80 | 483,457.10 | 29.29% |
| MO | St. James | 12,262 | 33.6 | 27.69 | 339,534.80 | 89,512.60 | 26.36% |
| MT | Columbia Falls | 21,583 | 59.0 | 28.25 | 609,719.80 | 157,555.90 | 25.84% |
| NB | Grand Island** | 45,798 | 125.5 | 37.15 | 1,701,395.70 | 334,325.40 | 19.65% |
| NJ | Menlo Park | 13,662 | 37.4 | 40.78 | 557,136.40 | 99,732.00 | 17.90% |
| NY | Oxford | 21,806 | 59.7 | 97.67 | 2,129,792.00 | 159,183.80 | 7.47% |
| ND | Lisbon | 37,826 | 104.0 | 24.48 | 925,980.50 | 276,129.80 | 29.82% |
| OH | Sandusky | 94,935 | 260.0 | 36.36 | 3,451,836.60 | 693,026.00 | 20.08% |
| OK | Ardmore | 24,561 | 67.6 | 44.72 | 1,098,367.90 | 179,295.30 | 16.32% |
| OK | Clinton | 10,570 | 28.9 | 48.61 | 513,807.70 | 77,161.00 | 15.02% |
| OK | Normon*** | 0 | 0.0 | 0.00 | 0.00 | 0.00 | 0.00% |
| OK | Sulphur | 5,655 | 15.5 | 45.42 | 256,850.10 | 41,281.50 | 16.07% |
| PA | Erie | 25,641 | 70.2 | 48.17 | 1,235,126.90 | 187,179.30 | 15.15% |
| PA | Hollidaysburg | 61,943 | 169.7 | 58.79 | 3,641,628.90 | 452,183.90 | 12.42% |
| RI | Bristol | 16,792 | 46.0 | 53.04 | 890,647.70 | 143,336.80 | 16.09% |
| SD | Hot Springs | 26,686 | 73.1 | 23.89 | 637,528.50 | 194,807.80 | 30.56% |
| VT | Bennington | 5,203 | 14.3 | 26.49 | 137,827.50 | 37,981.90 | 27.56% |
| WA | Orting | 21,793 | 59.7 | 48.57 | 1,058,486.00 | 159,088.90 | 15.03% |
| WA | Retsil | 51,466 | 141.0 | 39.13 | 2,013,864.60 | 375,701.80 | 18.66% |
| WV | Barboursville | 56,330 | 154.3 | 29.04 | 1,635,823.20 | 411,209.00 | 25.14% |
| WI | King | 16,722 | 45.6 | 42.83 | 716,203.30 | 122,070.60 | 17.04% |
| WY | Buffalo | 17,738 | 48.6 | 44.07 | 781,713.70 | 129,487.40 | 16.56% |

EXHIBIT D

VA FEDERAL GRANTS APPLICABLE TO DOMICILIARY, NURSING, AND
HOSPITAL CARE PROVIDED BY STATE HOMES

FY 1985

NURSING CARE TOTAL 41 WITH 2 ANNEXES

| | | COST SHARED BY VETERANS ADMINISTRATION & VETERANS HOME | | | | | |
|---|---|---|---|---|---|---|---|
| | | VETERAN DAYS OF CARE | AVERAGE DAILY CENSUS | AVERAGE PER DIEM COST | TOTAL VETERAN COST | GRANT-IN-AID BY VA | PERCENT OF COST |
| | Summary | 2,863,430 | 7,883 | $65.39 | $192,530,055.40 | $48,759,404.50 | 25.33% |
| CA | Yountville | 234,040 | 641.2 | 90.80 | 21,250,832.00 | 3,990,382.00 | 18.78% |
| CO | Florence | 35,203 | 96.5 | 49.31 | 1,735,859.90 | 600,211.20 | 34.58% |
| CO | Homelake | 7,836 | 21.5 | 46.58 | 365,000.90 | 133,603.80 | 36.60% |
| GA | Augusta | 63,220 | 173.2 | 61.46 | 3,885,501.20 | 1,077,901.00 | 27.74% |
| GA | Milledgeville | 77,322 | 211.8 | 110.04 | 8,508,512.80 | 1,318,340.10 | 15.49% |
| ID | Boise | 28,662 | 77.9 | 58.30 | 1,678,994.60 | 488,687.10 | 29.11% |
| IL | Quincy | 142,879 | 392.2 | 59.37 | 8,482,726.20 | 2,436,086.90 | 28.72% |
| IN | Lafayette | 89,975 | 245.8 | 54.11 | 4,868,547.30 | 1,534,073.70 | 31.51% |
| IA | Marshalltown | 185,021 | 506.9 | 75.49 | 13,967,235.30 | 3,154,608.10 | 22.59% |
| KS | Fort Dodge | 19,099 | 52.3 | 42.48 | 811,325.20 | 325,637.90 | 40.14% |
| LA | Jackson | 40,140 | 110.0 | 38.44 | 1,542,981.60 | 684,387.00 | 44.35% |
| ME | Augusta | 37,216 | 102.2 | 67.05 | 2,495,332.80 | 634,532.70 | 25.43% |
| MA | Chelsea | 18,796 | 51.7 | 39.94 | 753,907.40 | 321,835.80 | 42.69% |
| MA | Holyoke | 91,290 | 250.1 | 68.99 | 6,298,097.10 | 1,556,491.50 | 24.71% |
| MI | Grand Rapids | 198,519 | 544.0 | 65.37 | 12,977,187.00 | 3,384,748.90 | 26.08% |
| MI | Marquette | 22,228 | 60.0 | 71.66 | 1,592,858.50 | 378,987.40 | 23.79% |
| MN | Minneapolis | 108,016 | 296.0 | 52.05 | 5,622,232.80 | 1,841,672.80 | 32.76% |
| MO | Mexico* | 3,773 | 56.3 | 82.37 | 310,782.00 | 64,329.70 | 20.70% |
| MO | Mount Vernon | 34,788 | 95.3 | 43.35 | 1,508,059.80 | 593,135.40 | 39.33% |
| MO | St. James | 58,883 | 161.3 | 43.10 | 2,537,857.30 | 1,003,955.20 | 39.56% |
| MT | Columbia Falls | 22,330 | 61.2 | 58.42 | 1,304,518.60 | 380,726.50 | 29.19% |
| NE | Grand Island** | 180,074 | 493.3 | 55.42 | 9,979,701.80 | 3,070,261.70 | 30.77% |
| NH | Tilton | 32,116 | 88.0 | 57.75 | 1,758,431.30 | 547,577.80 | 31.14% |
| NJ | Menlo Park | 115,742 | 317.1 | 57.78 | 6,687,572.80 | 1,973,401.10 | 29.51% |
| NJ | Vineland | 93,683 | 256.6 | 75.54 | 7,076,813.80 | 1,597,295.20 | 22.57% |
| NY | Oxford | 23,574 | 64.6 | 108.70 | 2,562,493.80 | 401,936.70 | 15.69% |
| OH | Sandusky | 98,891 | 265.4 | 55.13 | 5,451,860.80 | 1,651,992.00 | 30.30% |
| OK | Ardmore | 37,338 | 102.2 | 66.84 | 2,495,671.90 | 636,612.90 | 25.51% |
| OK | Clinton | 46,376 | 127.0 | 74.35 | 3,448,055.50 | 790,710.80 | 22.93% |
| OK | Norman | 63,190 | 173.3 | 68.67 | 4,339,257.30 | 1,077,389.50 | 24.83% |
| OK | Sulphur | 47,846 | 131.2 | 79.25 | 3,791,795.50 | 815,774.30 | 21.51% |
| OK | Talihina | 57,058 | 156.3 | 70.88 | 4,044,271.00 | 972,838.90 | 24.05% |
| PA | Erie | 24,982 | 68.5 | 112.02 | 2,798,483.60 | 425,943.10 | 15.22% |
| PA | Hollidaysburg | 70,396 | 192.8 | 92.52 | 6,513,037.90 | 1,200,250.80 | 18.43% |
| RI | Bristol | 97,576 | 267.3 | 67.03 | 6,540,519.30 | 1,663,670.80 | 25.44% |
| SC | Columbia | 53,296 | 146.0 | 40.77 | 2,172,877.20 | 908,697.80 | 41.82% |
| SD | Hot Springs | 10,785 | 29.5 | 51.38 | 554,133.30 | 154,545.80 | 27.89% |
| VT | Bennington | 43,434 | 118.9 | 64.15 | 2,786,291.10 | 740,549.70 | 26.58% |
| WA | Orting | 37,626 | 103.1 | 66.64 | 2,507,396.60 | 641,523.30 | 25.59% |
| WA | Retsil | 48,173 | 131.9 | 67.87 | 3,269,501.50 | 821,349.70 | 25.12% |
| WI | King | 162,038 | 442.8 | 69.45 | 11,253,539.10 | 2,762,747.90 | 24.55% |

EXHIBIT D

### VA FEDERAL GRANTS APPLICABLE TO DOMICILIARY, NURSING, AND HOSPITAL CARE PROVIDED BY STATE HOMES

FY 1985

HOSPITAL CARE TOTAL 7

| | COST SHARED BY VETERANS ADMINISTRATION & VETERANS HOME | | | | | |
|---|---|---|---|---|---|---|
| | VETERAN DAYS OF CARE | AVERAGE DAILY CENSUS | AVERAGE PER DIEM COST | TOTAL VETERAN COST | GRANT-IN-AID BY VA | PERCENT OF COST |
| Summary | 182,076 | 499 | $210.15 | $29,307,597.90 | $2,776,659.40 | 9.47% |
| CA Yountville | 9,575 | 26.2 | 445.93 | 4,269,775.70 | 146,018.70 | 3.42% |
| CT Rocky Hill | 110,580 | 302.8 | 121.72 | 13,459,797.60 | 1,686,345.00 | 12.53% |
| IL Quincy | 5,781 | 15.9 | 199.87 | 1,155,448.50 | 88,160.60 | 7.63% |
| IA Marshalltown | 6,788 | 18.6 | 171.30 | 1,162,784.40 | 103,517.00 | 8.90% |
| MA Chelsea | 44,241 | 121.2 | 183.21 | 8,105,393.60 | 674,675.30 | 8.32% |
| MA Holyoke | 4,714 | 12.9 | 235.31 | 1,109,251.30 | 71,888.50 | 6.48% |
| OK Sulphur | 397 | 1.1 | 113.72 | 45,146.80 | 6,054.30 | 13.41% |

KEY:

* = New State Homes recognized during the fiscal year.

** = State Home with Annexes.

*** = State Home Nursing Home that retains 4 Domiciliary Beds.

Column 3 - Average Per Diem Cost - The State Home per diem cost is based on the cost of operation divided by the total days of patient (veteran/non-veteran) care during the fiscal year. The average per diem cost is the total veteran cost divided by the total veteran days of care.

Column 5 - Grant-In-Aid by VA - The per diem rates for FY 1985 were $7.30 for domiciliary care, $17.05 for nursing home care, and $15.25 for hospital care.

NOTE: Cost figures are unaudited.

Office of Extended Care (182C)
Department of Medicine & Surgery
Veterans Administration
Washington D. C.

FEBRUARY 4, 1986 EXHIBIT E

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

## SUPPORT RATIONALE FOR A PROPOSAL BY THE NATIONAL ASSOCIATION OF STATE VETERANS HOMES FOR AN INCREASE IN PER DIEM PAYMENTS FROM THE VETERANS ADMINISTRATION.

The National Association of State Veterans Homes respectfully requests that the per diem rates paid by the Veterans Administration to the states for the care of eligible veterans within State Veterans Homes be established in the 1987 Veterans Administration budget at $23.60 per day for nursing home care, $14.10 per day for domiciliary care and $76.25 per day for hospital care. In reviewing the federal-state partnership which exists through the Veterans Administration-State Home Program, the Congress has traditionally held that the Veterans Administration rate should be 30 percent of the average daily rate of all homes participating in the State Home Program. Public Law No. 98-160 established that the adequacy of the rates paid to the state homes would be reviewed by the Veterans Administration every third year. The first such report is to be submitted not later than June 30, 1986.

With this in mind, the National Association in developing this request, took the period 1987 through 1989 and established the rate at the estimated mid-point of the triennial review period. The law already provides that in no case shall the payments made with respect to any veteran exceed one-half of the cost of the veteran's care in a State Home.

Published comments on the draft of the Executive Order 1987 Budget indicate that the proposal calls for a "new long-term care policy," emphasizing the use of community nursing homes and state institutions rather than additional federal facilities. The State Home Program has for years proven itself a high quality, cost-effective alternative to the direct provision of care in federal facilities, a fact which the Executive Budget seems to recognize. However,

EXHIBIT E

this recognition comes at a time when several state home facilities are dealing with hiring freezes, budget cuts and similar restrictive measures reflecting fiscal problems being encountered by many states. Continuation of the current per diem rate will be seen as a further disincentive to both the full operation of existing state home facilities and the creation of the needed additional beds to accommodate the large and rapidly aging population of World War II veterans now coming into our facilities in significant numbers.

The National Association of State Veterans Homes notes, according to the Consumer Price Index, December 1985, a national inflation rate in health care services hovering around 6.8 percent with a longitudinal appearance of an upward spiral. The experience of the state home facilities further demonstrates their cost-effectiveness in that state homes are experiencing a 6.42 percent annual inflation rate. This inflation rate is built into the base calculations for the rates being requested.

The attached table illustrates the calculation base used by the National Association of State Veterans Homes in determining the requested rates. We observe that all rates are currently well below the 30 percent target share and further note that the soon-to-be-finalized Veterans Administration Regulations changing the focus of domiciliary care to a rehabilitative mode carry a strong potential for adverse impact on the cost of operations of state home domiciliaries.

It is important to note the role which the state home program plays in the overall scope of long-term care provided to veterans. The Veterans Administration nursing home units are increasingly focusing their efforts on the short-term

EXHIBIT E

rehabilitation of hospitalized veterans. Care in community contract homes is normally limited to a period of six months with some options for renewal. The care furnished by the state veterans facilities is typically for severely disabled or impaired veterans who demonstrate a need for receiving nursing care over a protracted period of time, thus placing the state homes in the unique position of caring for severely debilitated patients requiring extensive amounts of care over a long-term period.

This has become increasingly noticeable with the advent of the Diagnosis Related Groups (DRG) concept of providing care in community acute care facilities and presently being implemented in the Veterans Administration Medical Centers. Without an adequate federal reimbursement structure for the states sponsoring state veterans homes, the expansion and/or full utilization of present capacity required for this long-term nursing care will not exist at that precise time in history when it is most critically needed.

It is thus that the National Association of State Veterans Homes urges your serious consideration and your subsequent approval of this request for improved per diem payments from the Veterans Administration to states for health care services provided veterans within state veterans facilities.

Jack J Dack

Jack J. Dack, Commandant
Iowa Veterans Home
Marshalltown, Iowa
Legislative Chairperson
National Association of
State Veterans Homes

JJD:rah

Attachment

EXHIBIT E

## NATIONAL ASSOCIATION OF STATE VETERANS HOMES

## COMPARISON OF VETERANS ADMINISTRATION AND STATE HOME ACTUAL COSTS, PER DIEM PAYMENTS AND ESTIMATED COSTS

## FOR THE YEARS ENDING SEPTEMBER 30, 1984 THROUGH 1989

| | 1984 | | 1985 | | 1986 | | 1987 | 1988 | 1989 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual Aver. VA Payments or Costs | Actual Aver. State Home Costs | Actual Aver. VA Payments or Costs | Actual Aver. State Home Costs | Estimated Aver. VA Payments or Costs | Estimated Aver. State Home Costs (1) | Estimated Aver. State Home Costs (1) | Estimated Aver. State Home Costs (1) | Estimated Aver. State Home Costs (1) | 30% of 87-89 Avg.(2) | Per Diem Rates To Be Requeste (2) |
| NURSING HOME CARE: | | | | | | | | | | | |
| Veterans Administration | $ 107.84* | | $ 111.94 | | $ 113.84 | | $ 120.04 | | | | |
| Community Contract | $ 55.19* | | $ 59.87 | | $ 64.38 | | $ 69.53 | | | | |
| State Home Program | $ 14.60 | $ 60.84 | $ 17.05 | $ 65.39 | $ 17.05 | $ 69.24 | $ 73.74 | $ 78.53 | $ 83.63 | $ 23.59 | $ 23.60 |
| Percentage of VA Payment to State Home Costs | | 24.00% | | 26.07% | | 24.62% | | | | | |
| DOMICILIARY CARE: | | | | | | | | | | | |
| Veterans Administration | $ 41.65* | | $ 43.62 | | $ 44.70 | | $ 45.11 | | | | |
| State Home Program | $ 7.10 | $ 37.61 | $ 7.30 | $ 37.62 | $ 7.30 | $ 41.42 | $ 44.11 | $ 46.98 | $ 50.03 | $ 14.11 | $ 14.10 |
| Percentage of VA Payment to State Home Costs | | 18.88% | | 19.40% | | 17.62% | | | | | |
| HOSPITAL CARE: | | | | | | | | | | | |
| Veterans Administration Intermediate Care Beds | $ 122.33** | | $ 135.22 | | $ 141.02 | | $ 145.09 | | | | |
| State Home Program | $ 13.84 | $ 198.16 | $ 15.25 | $ 210.15 | $ 15.25 | $ 223.81 | $ 238.36 | $ 253.85 | $ 270.35 | $ 76.26 | $ 76.25 |
| Percentage of VA Payment to State Home Costs | | 6.98% | | 7.26% | | 6.81% | | | | | |

NOTES: (1) The State Home Program estimated costs are based on an annual inflation rate of 6.5% and was arrived at using the current cost data.

(2) Historically the per diem rate paid by the V.A. has been based on 30% of the average daily rate of all homes participating in the State Home Program.

* Summary of medical programs September, 1985, VA Office of Information, Management and Statistics.

** Medical programs Fiscal Year 1986 Volume II Office of Budget and Finance (Controller), Washington, D.C.

EXHIBIT F

# Memorandum of Understanding
*between the*
# Veterans Administration
*and*
# National Association of State Veterans Homes

The Veterans Administration (VA) and the National Association of State Veterans Homes (NASVH) agree to work together, as set forth in this memorandum of understanding, for the purpose of achieving their mutual goal of providing quality care for veterans.

There has been a longstanding relationship between the VA and the State Veterans Homes. The Federal government began per diem payments to state homes in 1888 for veterans receiving domiciliary care. The Federal assistance to state homes was expanded in 1939 to include hospital care. In 1964, P.L. 88-450 further expanded the Per Diem Grant Program to include veterans receiving care in State Home Nursing Homes and initiated the State Home Construction Grant Program. State Home Per Diem Grants and State Home Construction Grants are approved and administered by the Veterans Administration within defined legislative authority. Each State that chooses to participate in either or both of the State Home Grants Programs initiates and controls the overall establishment, management, and operation of a state home within defined Federal, State, and local regulations. Therefore, the State Home Program is a Federal-State cost sharing program with each entity having specific responsibilities.

The National Association of State Veterans Homes (NASVH) was established in 1952 as an integrated entity for the purposes of 1) promoting legislation on the national level, and 2) sharing problems and experiences common to all State Homes. The most recent goals adopted by the NASVH are:

1. to provide appropriate quality care services to eligible disabled and elderly veterans and their dependents in State Veterans Homes;

2. to provide a clearinghouse for techniques and expertise in the care of veterans and the management of our institutions (State Homes);

3. to insure solidarity in the presentation of State Home requirements to Congress and the VA and of their responsibility of meeting these needs;

4. to encourage continued financial participation of the Federal government in the construction of state home facilities and the care of veterans in state homes; and

5. to encourage and assist other states to establish new state homes.

The VA and the NASVH have the mutual goal of providing quality care to veterans. Therefore, both organizations agree to work togther to identify areas for enhancing the quality of care for veterans through exchanging facts and information concerning the care of veterans

Goals: The following are the initial goals to be achieved:

1. to exchange information on efforts to encourage and assist states to establish new state homes, and expand/renovate existing state homes and state home programs.

2. to exchange information on VA and state home resources that could be shared under current legislative authority governing the VA and each state home.

3. to establish a formal means of exchanging information on the results of research and experience related to planning for and provision of long term care of veterans conducted by the VA, state homes, NASVH, and/or other agencies or individuals involved in long term care.

**Implementation Plan:**

The VA and the NASVH representatives would meet on a quarterly basis to develop strategies and target dates for implementing the goals. Subject areas may include:

- **Information Sharing and Dissemination**

1. current methods of encouraging and assisting states to establish new state homes;

2. types of medical information which the respective organizations might exchange in such areas as geriatrics and gerontology, medical research, long term care service delivery, and cooperative health care education services.

3. listings of VA and State Home officials responsible for planning, maintaining and evaluating quality health services for veterans in need of long term care.

4. current representatives of the VA and State Homes in planning, maintaining and evaluating quality health services for veterans in need of long term care.

- **Review and Implementation Procedures**

1. identify plans for fully implementing the joint goals.

2. determine resources available and needed for implementing the plan.

3. designate individuals responsible for implementing specific strategies in the plan.

4. specify target dates for accomplishment of the plan.

5. reevaluate the goals and implementation plans on an annual basis.

The undersigned agree to designate appropriate representatives to meet and address the stated goals on this agreement.

*The undersigned hereby endorse this memorandum of understanding in the city of Washington, D.C. on the 24th day of February, 1986.*

Acting Administrator of Veterans Affairs

President, NASVH

Chief Medical Director

Chairman VA-NASVH Liaison Committee

Assistant Chief Medical Director for Geriatrics and Extended Care

Secretary/Treasurer NASVH

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

## ORAL TESTIMONY

APRIL 22, 1986

To The
Subcommittee on Hospitals and Health Care
Veterans' Affairs Committee

Support for legislation to extend the
Authority for the Program of Construction
Grants to states for State Home Facilities:
"Older Veterans Health Amendments and the
Extension of the Authority of Certain Medical Programs."

Presented by:
Frederick Traill, Chairman
National Association of State
Veterans Homes
Liaison Committee
Past President, NASVH
Commandant, Michigan Veterans
Facility
Grand Rapids, Michigan

Mr. Chairman, my name is Frederick Traill. I am the Commandant of the Michigan Veterans Facility in Grand Rapids, Michigan. With me today are Jerry Stewart, President Elect of NASVH and Administrator of the Sulpher, Oklahoma, Veterans Center, and Jack J. Dack, Commandant of the Iowa Veterans Home and Legislative Chairman of NASVH. We have submitted our written testimony and request that it and our oral testimony be made part of the permanent record of this hearing.

We thank you Mr. Chairman, your fine staff, the staff of the full Committee, and the Veterans Administration for your assistance in adding back some $20 million for the State Home Construction Budget in the President's proposed fiscal year 1987 budget. We strongly support the extension of the Construction Grant Program and would hope you would consider a greater than 3-year extension.

We are extremely pleased that the Committee, as stated in your discussion draft, wants to further increase construction funds to $50 million in FY 1987. We feel that this increase will assist in reducing the backlog of projects currently awaiting funding.

As you know, Mr. Chairman, presently there are 35 states with State Veterans Homes. There are six states which have expressed some interest in establishing a State Veterans Home. The remaining nine states have exhibited little or no interest in establishing a State Veterans Home Program. While we recognize the need to encourage new states to come on line with new programs, we have serious reservations about the concept of prioritization as expressed in your discussion draft of April 11, 1986.

In our view, the construction of state veterans homes would become a Federal initiative at the precise time when the emphasis in government is cooperation and enhanced partnership between the states and the Federal Government. We, the State Veterans Homes, are the pioneers in the arena of long-term veteran health care.

The procedures in the discussion draft would work effectively in the short-term to resolve the problem of new states coming into the program. In our view, it does little to encourage states already in the program to effectively plan for long-term expansion of capacity, remodeling, and/or renovation to meet life safety standards or other regulatory requirements.

Last year in a letter sent to Chairman Montgomery, at the request of Subcommittee staff, we answered a question you raised in the discussion draft which eventually became House Resolution 505 as to whether..."we could support a division of the Construction Grant Appropriation into separate pockets for (1) funding of new Homes in new states and (2) funding the correction, renovation, and expansion of Homes already existing." We concurred in this approach, but note that the concept did not appear in the language adopted by the Subcommittee and forwarded to the full Committee. We also note that our suggestion is not included in your discussion draft of April 11, 1986. We would like to submit, for the record, a copy of the above mentioned letter. (Attached).

We would find the discussion draft more acceptable if you (1) actively support funding of the levels identified in your draft and (2) create two lists of funding recommendations, one being for new Homes in states not currently providing State Home Services and a second list for states desiring to improve or expand their facilities. Within each list, NASVH supports continuation of "first-come, first-served" prioritization.

As for the "One-third Rule," the Association narrowly voted to oppose removal of that limitation.

As we have stated in our written testimony, "Increased funding for state construction projects will be a step in the right direction. However, it is important that the per diem rates which are prescribed by the law reflect the same consideration. Both sections of the program, construction and per diem, must walk hand-in-glove for the capacities to exist in the states to absorb the additional work load which will result both from the shifting of service from the Veterans Administration and from the aging of the veteran population in the states themselves. Appropriate levels of funding in both programs must be maintained to encourage those states currently providing veterans home services to retain and expand these services as well as to encourage additional states not currently providing state veterans homes to get into the program." Appropriate levels of per diem funding can only be maintained through an annual rate review mechanism such as already exists for the VA Nursing Care Programs and the community contract nursing homes. We also state in our written testimony that we fervently oppose a move to combine the Office of Geriatric and Extended Care with an Office of Clinical Affairs. This combination would skew to acute care orientation to the detriment of millions of aging veterans.

Mr. Chairman, we appreciate this opportunity to come here from Iowa, Michigan, and Oklahoma to testify before you. We look forward to working closely with you and your staff to improve an already successful, cost-effective, and vital program. Thank you.

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

OFFICE OF Chairperson, Legislative Committee

May 3, 1985

Honorable G.V. (Sonny) Montgomery, Chairman
Committee on Veterans' Affairs
House of Representatives
Room 335
Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

The National Association of State Veterans Homes appreciated the opportunity to have its Legislative Committee present testimony to the Sub-Committee on Hospitals and Health Care on May 2, 1985, on the matter of HR-505, the Veterans Health Care Omnibus Bill. Our testimony dealt specifically with that part of the Bill relating to revision of the State Home Construction Grant Program.

Our Legislative Committee was privy, on very short notice, only to the discussion draft of the proposed amendments to the State Home construction funding mechanism. The discussion draft contained several provisions which we felt were detrimental to the total effort of Congress and the states to achieve greater state participation in veteran health care and our comments reflected this concern.

The National Association of State Veterans Homes Legislative Committee attended the markup session for the bills and thus became aware of the Committee's more recent version of State Home Construction Grant Amendments which the Sub-Committee adopted for reporting to the Full Committee on Veterans' Affairs. We have carefully reviewed the adopted amendments and are pleased to inform you that they are fully supported by the National Association of State Veterans Homes.

One major concern expressed by the Sub-Committee was that the current "first-come, first-served" grant award system operates to discourage those states newly interested in the Program from making application for federal funds. This discouragement was seen as a byproduct of the long waiting list for those funds which now exists due to the fact that states already providing State Home services have initiated action to get into the queue for funding. States not currently operating homes have not had the benefit of knowledge of the Program or how to use it.

Congressman Edgar questioned us as to whether we could support a division of the Construction Grant Appropriation into separate pockets for (1) funding of new Homes in new states, and (2) funding the correction, renovation and expansion of Homes already existing. We concurred in this approach but note that the concept did not appear in the language adopted by the Sub-Committee and forwarded to the Full Committee.

In an effort to assist with a resolution to the priority problem, we would respectfully offer an implementory suggestion. Perhaps it would be appropriate for the Committee Report directing Veterans Administration implementation of HR-505 to require that the Administrator's report submitted under Title 38, 5033a, 2A and B (i)(ii), contain two lists of recommendations; one being for new Homes in states not currently providing State Home services, the second being for states desiring to improve or expand their facilities. In this manner, we believe, a more equitable method for attracting new states into this cost-effective Program could be developed without penalizing existing State Homes. This could prove beneficial to both State and Federal Agencies, particularly if the appropriated program funding matches the authorized amounts contained in HR-505.

Mr. Chairman, let me again assure you that the National Association of State Veterans Homes fully supports your Committee's effort to enhance expansion of the State-Federal partnership which is so well developed in the operation of State Veterans Homes. We are pleased to support HR-505 and hope that our suggestion is worthy of further consideration.

Sincerely,

Jack J Dack

Jack J. Dack
Chairperson, Legislative Committee
National Association of State
Veterans Homes
Commandant, Iowa Veterans Home
Marshalltown, IA 50158

JJD:rah

cc: See attached list

cc: Honorable Robert W. Edgar
Congress of the United States
U.S. House of Representatives
2352 Rayburn House Office Building
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## ANALYSIS OF ELIGIBLE PREAPPLICATIONS AND APPLICATIONS FOR GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES - 2/28/86

PROBLEM:

| NUMBER OF PROJECTS | | EXPLANATION | DOLLARS |
|---|---|---|---|
| 46 | 65.72% | Non-Bed Producing Projects | |
| 10 | | Fire and Life Safety | $10,785,000 |
| 20 | | Renovation of Existing Care Facilities | $36,616,000 |
| 12 | | Remodeling of Support Facilities such as Dietary and Power Plants | $10,694,000 |
| 4 | | Grant Increases | $ 985,000 |
| | | | $59,080,000<br>33.72% |

| NUMBER OF PROJECTS | | EXPLANATION | STATE | DOLLARS |
|---|---|---|---|---|
| 24 | 34.28% | Bed Producing Projects | | |
| 14 | | Projects involving eleven states, already possessing state homes, who wish to add new homes and/or additional beds: | | |
| | | | NJ Paramus | $11,644,000 |
| | | | NY Long Island | $14,780,000 |
| | | | WV Pruntytown | $ 5,563,000 |
| | | | MO SE and SW | $11,700,000 |
| | | | OK Claremore | $ 8,450,000 |
| | | | PA Pennhurst | $11,681,000 |
| | | | SC Anderson | $ 5,850,000 |
| | | | ID Eastern ID | $ 2,979,000 |
| | | | IA Clarinda | $ 2,118,000 |
| | | | ME Biddeford | $ 4,875,000 |
| | | | MI Macomb | $ 3,307,000 |
| | | | | $82,947,000<br>47.35% |

These projects will increase the bed capacity by 2430 NHC beds and 350 Dom beds.

EXHIBIT D

## ANALYSIS OF ELIGIBLE PREAPPLICATIONS AND APPLICATIONS FOR GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES - 2/28/86

Continued from Page 1

| NUMBER OF PROJECTS | EXPLANATION | STATE | DOLLARS |
|---|---|---|---|
| | Bed Producing Projects - Continued | | |
| 3 | Requests from 3 states which have not previously had State Facilities: | | |
| | | MS Jackson | $ 4,388,000 |
| | | FL Lake City | $ 2,730,000 |
| | | AL Alexander City | $ 4,615,000 |
| | | | $11,733,000<br>6.70% |
| | Bed capacity will increase by 300 NHC beds and 150 Dom beds. | | |
| 7 | Requests from six states already possessing State Homes who wish to increase the bed capacity of their existing facilities: | | |
| | | MD Charlotte Hall | $ 8,345,000 |
| | | MT Columbia Falls | $ 1,203,000 |
| | | GA Milledgeville | $ 4,550,000 |
| | | MO St. James | $ 2,420,000 |
| | | OH Sandusky | $ 2,918,000 |
| | | OK Talzhina | $ 1,999,000 |
| | | | $21,435,000<br>12.23% |
| | This will increase bed capacity by approximately 653 NHC beds. | | |
| 70 Projects 100.0% | | TOTAL DOLLARS | $175,195,000<br>100.00% |

bg/ 04-17-86

Page 2

EXHIBIT D

**American Ex-Prisoners of War**

CONGRESSIONALLY CHARTERED
NATIONAL HEADQUARTERS
(817)649-AXPW
3201 EAST PIONEER PARKWAY, SUITE 40 ● ARLINGTON, TX 76010

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STATEMENT BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

BY

ORLO G. NATVIG, NATIONAL COMMANDER

AND

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AMERICAN EX-PRISONERS OF WAR

WITH RESPECT TO S. 2168

A BILL TO EXPAND VETERAN BENEFITS FOR

FORMER PRISONERS OF WAR

WASHINGTON D.C. MAY 20, 1986

**WE EXIST TO HELP THOSE WHO CANNOT HELP THEMSELVES.**

Mr. Chairman and Distinguished Members of the Committee. Once again we come before this Committee to plead the cause of former prisoners of war.

Once again we wish to express our appreciation to the Committee for the opportunity to do so. We are deeply grateful for the compassion Congress has already shown- and for your early recognition that there would be long-term health consquences to inhumane treatment that occurred during captivity.

In it's 1980 Study of Former Prisoners of War, VA also acknowledged it's debt to Congressional leadership. It stated "Congessional concern about former POWs having significantly higher incidence and greater variety of diseases attributable to internment is well-found."

While we also appreciate the compassion VA has expressed toward POWs, we respectfully call to your attention that VA has almost invariably awaited Congressional leadership rather than initiated legislative proposals on it's own. Not only did the 1980 Study document the statistically significant occurence of the conditions included in S. 2168 and H.R. 4333, but also VA acknowledged in it's 1984 POW Phamplet that "avitaminosis would affect many parts of your body and cause delay disabilities." This conclusion has also been unanimously supported by the medical experts on the VA POW Advisory Committee.

Mr. Chairman, the testimony we submitted to the Veterans Affair Committee of the House of Representatives on June 19, 1985 with respect to H.R. 864 is pertinent to a discussion of the two conditions contained in S. 2168. We ask that it be considered as supplementary to the specific comments I would now like to make. We also continue to believe that the several additional conditions included in H.R. 864 merit favorable consideration.

## ORGANIC RESIDUALS OF HYPOTHERMIA

Mr. Chairman, the U.S. Naval Medical School published a Polar Manual in 1962 in which it notes that cold injuries may cause numerous sequelae and serious delayed effects may occur after a very long time. In World War II, U.S. Forces suffered 90,000 cold injuries, and 10% of U.S. casualties in Korea were for these same conditions. These casualties were reported for armed forces still under U.S. control where all possible efforts were made to prevent them, and where evacuation and treatment could be provided at the earliest possible moment. POWs were not included in these statistics. They endured the same adverse weather conditions prior to capture and far worse conditions after capture with no treatment whatsoever. In fact, they were frequently deprived of their shoes and protective clothing, were exposed to the cold for long periods on marches, punishment, or while on forced work details.

As a result, the great majority of POWs captured or confined under such conditions suffered cold injuries. It was almost impossible to escape such injury.

Why were these cold injuries not discovered by the military or reported by the POWs at the time of repatriation or separation from service? As has been well documented by studies of POW records, circumstances at those times were such that medical examinations wre typically inadequate. This was compounded by the fact that POWs who had learned to endure many health problems during confinement typically did not report them. Also they were so happy to be free and eager to get home they brushed these problems aside not realizing the importance of getting the information on military or early VA records.

Despite these limiting factors, VA statistics reveal still that service connection for cold injuries among POWs is significabtly higher than for other combat veterans serving in the same areas. It is obvious that the actual number sustaining residual damage is far higher than the number already identified as service connected. Now, when they seek service connection, they are typically turned down because of the lack of medical evidence in their records and/or the years that have transpired since their POW days. They are denied service connection even though the residual sequelae are present and the veterans give a credible history supporting the claims. Those who do eventually receive service connection do so only after a protracted, costly and frustrating period of time. Not infrequently, examining physicans have had little experience with cold injury. While recognizing that pathology is present, they lack the knowledge to make the causal connection.

With respect to the diagnostic problem, your attention is called to the 1983 publication entitled "Management of Wilderness and Environmental Emergencies" edited by Drs. Paul S. Auerbach and Edward C. Geehr. It contains a detailed dicussion of Hypothermia and Cold Injuries for which some two hundred references are cited. The process by which residual and delayed damage occurs to cutaneous surfaces, tissue, vascular system, nervous system and bone structure is reviewed or cited. They note that individual variability in cold-induced vasodilatation may explain some of the variation in susceptibility to frostbite (and residual injury).

Mr. Chairman, the evidence of POW exposure to cold under the worst possible conditions is overwhelming despite the paucity of service and early VA records documenting this for individual POWs. VA's own records support the conclusion that POWs do suffer from the residual effects to a significant degree yet POWs now presenting these claims typically face denial or receive service connection only after repeated claims and protracted time.

Congressional action to make this a presumptive condition is a fair, justifiable and reasonable solution, and we so recommend it.

## ARTHRITIS DUE TO TRAUMA

Mr. Chairman, trauma among airmen escaping from falling aircraft was frequent and inescapable. Forced parachute landings were made during the night and they landed on frozen ground or in trees. Many were wounded and semi-conscious at the moment of impact. They were typically unable to protect themselves.

Captured ground forces were subjected to extreme combat conditions involving prolonged shelling and mortar fire. They were often wounded, exhausted or dazed at the time of capture.

Both ground and air forces were subject to brutal treatment immediately after capture and throughout confinement. Most were subjected to injuries from rifle butts or other objects. They sustained this trauma to their bodies without treatment and while they were being starved and deprived of the minimal level of nutrients essential to the recovery of tissue, cartilage and bone from this trauma. Not only was the normal healing process diminished and treatment non-existent, but also they were forced to work long hours for their captors in mines or fields under the most extreme conditions. Cold and dampness were ever-present.

After repatriation, if they were given any examination at all, it was hurried and inadequate for identifying only the most obvious injuries. Separation examinations were group conducted and inadequate for documenting trauma. In these separation centers, warnings were given that servicemen presenting complaints would have their discharge delayed. As was said before, POWs simply did not report their injuries although, in retrospect, they clearly should have done so.

Traumatic arthritis is reviewed in considerable detail in the 1985 tenth edition of Arthritis and Allied Conditions, edited by Daniel J. McCarty, M.D., with more than one hundred references cited. In the introduction to the chapter on traumatic arthritis, they indicate that, even in osteoarthritis ordinarily considered to be synonymous with traumatic arthritis, increasing emphasis is being placed on altered cartilage metabolism in addition to trauma which altered the structural integrity of joints. The gradual development of arthritic conditions in damaged joints, with a history of malnutrition at the time of and subsequent to injury, is the typical pattern presented in POWs.

The extensive clinical studies of protocol examinations at VAMC Loma Linda confirm on a general sample of POWs that there is a high incidence of degenerative joint diseases and osteoporosis, not infrequently beginning at a relatively young age.

Mr. Chairman, while such claims represent a major area of disabilities for POWs, it is also the area of the greatest number of denials according to DVB statistics from 1981 through 1984. BVA data for 1983 also indicates that only 2 of 45 appeals were allowed for such conditions. The absence of service medical records and the passage of time before the claim is made are the primary reasons deserving POWs, who did sustain considerable trauma and are having arthritic changes in the area of the trauma, are denied service connection. Where the denial acknowledges the original injury, it justifies this action on the basis of the unprovable assumption that complete recovery had occured prior to the present, diagnosed medical problem. Current medical knowledge does not support such adverse conclusions where the history of injury and forced continued use of the area, under conditions of malnutrition and exposure, is present as it is in most POW claims.

Congressional action to make this a presumptive condition is a fair, justifiable and reasonable solution, and we so endorse it as contained in S. 2168.

## SPASTIC COLON (Irritable Bowel Syndrome)

Mr. Chairman, gastro-intestinal difficulties were rampant in prison camps and coping with them was a way-of-life for POWs. These symptoms resulted from a combination of factors: inadequate and rotten or inedible food, unsanitary conditions, malnutrition, stress, exposure to the elements and continuing deterioration of health. The symptoms persisted throughout confinement yet POWs were forced to work regardless of severe cramps and uncontrollable diarrhea. After repatriation and separation from service, most POWs recovered to the degree that symptoms were no longer disabling, although few POWs are totally free of residual problems in this area. A significant number, however, have continued to experience an embarrassing and disabling degree of these symptoms.

At the time of repatriation, POWs did acknowledge these problems and they were well known to medical personnel involved in POW care. However, a diagnosis was infrequently made except in cases where bacterial or protozoan sources were identified.

The absence of diganoses in service and early VA medical records almost invariably led VA to conclude the absence of a disabling condition for many POWs. However, some have been rated service connected for comparable symptoms and similar histories of continuing problems.

Gastrointestinal Disease, Third Edition, 1983, edited by Marvin H. Sleisenger, M.D. and John S. Fordtran, M.D., discusses this chronic condition and provide some sixty-seven references. The condition is described as one of the least understood disorders because it is a syndrome composed of a number of conditions with similar manifestations. It is described as a motor disorder with an absence of detectable organic pathology. As such, emotional stress can play a triggering role. However, cholinergic agents are described as more potent in producing the colonic hyperactivity. It is described as a chronic disorder with symptoms that may vary from patient to patient. While remissions may occur and last several years, "reoccurrence is the rule". The review also indicates that this can be a progressive disorder rather than simply a continuing or recurrent one.

VA medical personnel and rating boards certainly have misunderstood and discounted this condition despite the fact that former POWs describe it's chronic occurrence and disabiling effect in considerable detail. The continued dismissal of this condition when it is so disruptive of the daily life of maby POWs is unwarranted and unfair. Establishing spastic colon or irritable bowel syndrome as a presumptive disease is the only reasonable and fair solution that has not been, and will not be, solvable under existing laws and regulations.

Mr. Chairman, in closing, this proposed legislation will do much to help POWs with respect to two disabling conditions known to both treating and research professionals to be common residuals of their captive experiences. These are conditions fully warranted by historical facts and medical findings yet extremely difficult to obtain service connection for POWs under the present law. The addition of these two conditions to the presumptive list, would make it possible for a small number of deserving POWs to obtain benefits that are currently being effectively denied.

Thank you.

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# STATEMENT BEFORE THE
# COMMITTEE ON VETERANS' AFFAIRS
# UNITED STATES HOUSE OF REPRESENTATIVES

BY

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AMERICAN EX-PRISONERS OF WAR

WITH RESPECT TO H.R. 854
A BILL TO EXPAND VETERAN BENEFITS FOR
FORMER PRISONERS OF WAR

WASHINGTON, D. C. JUNE 19, 1985

Mr. Chairman and Distinguished Members of the Committee

Thank you for the opportunity to speak on this legislation so vital to the 85,000 still-living survivors of incredible brutal and harsh POW experiences. As you know, our numbers are dropping rapidly. Nearly 9,000 have died since the passage of PL 97-37 only four short years ago!

We intend to show the Committee that the proposed additions to the presumptive list contained in this bill are fully warranted and, we urge, out of humanitarian considerations, prompt and favorable action. We believe the cost will be largely offset by the elimination of the protracted adjudication procedures now typically requiring years to complete.

The Former Prisoner of War Benefits Act of 1981 (PL 97-37) was a godsend to POWs and we will remain eternally grateful to the House Veterans' Affairs Committee for its strong and compassionate support. That legislation opened up the doors of the VA health care system to many ill and desparate POWs. It also expanded the presumptive list for determination of service connection by adding anxiety states. With the subsequent addition of dysthymic disorders as a part of PL 98-223 in 1984, Congress has fully addressed the long-term psychiatric consequences of the POW experience.

However, Mr. Chairman, that legislation did not expand the presumptive list to include any additional long-term physical disabilities. Rather, it mandated the establishment of a POW Advisory Committee comprised of medical experts in fields pertinent to disabilities prevalent among POWs, as well as POWs representative of the various wars and divergent theaters of operation within those wars. That Committee was charged with assessing the needs of POWs with respect to possible service connection for other disabilities, and for making appropriate recommendations for administrative and legislative action.

The Advisory Committee concluded, unanimously and without reservation, in its 1983 report, that the starvation and deprivation of the POW experience was unquestionably causally related to later health problems in all major body systems! It did so after careful review of research findings and expert opinion over the 40-years that have transpired since WWII. The medical subcommittee even met with 9 consultants long known for their expertise in POW matters prior to their decision.

The Committee further noted that, despite the passage of 40 years, the POW presumptive list of physical conditions was, with the exception of helminthiasis and chronic dysentery, entirely limited to acute nutritional deficiency-related diseases and their immediate consequences. Entirely absent from the presumptive list, Mr. Chairman, are the slowly developing and delayed physical conditions so clearly anticipated by the War Crimes Commission in 1950, by Congressional hearings that same year, and by a special interagency committee appointed by President Eisenhower in 1956. They all confirmed what the VA Administrator previously stated in 1948. Here are but a few quotes from those earlier assessments.

> "the near-starvation diets...impaired their internal organs...in many cases the effects of such malnutrition would escape detection in ordinary physical examinations because such symptoms are not detectable...or show up long afterwards." (VA Administrator, 1948)

> "Effects of certain dietary deficiencies may be irreversible...Real problems involve disabilities which are difficult or impossible to detect by objective measures or tests...these techniques are completely useless to evaluate... individuals who have suffered from active malnutrition 10 or more years previously." (President Eisenhower Committee, 1956)

Indeed, even the 1984 Revision of VA's pamphlet "Benefits for Former POWs" specifically states:

> "avitaminosis may affect many parts of your body and cause delayed disabilities."

Mr. Chairman, the POW Advisory Committee found that, despite this general recognition, when it came to individual POW claims current VA methods of determining disability and deciding service connection were totally inadequate. It understood VA's concern that the overall integrity of the adjudication system was contingent on the established policies and procedures, yet emphasized that justice and fairness to all categories of veterans must be a guiding principle. It noted that medical science has not progressed to the point of confirming a specific etiological process for relating given conditions to the deprivation and malnutrition of the POW experience. Thus, the current adjudication approach was simply not applicable to legitimate claims of POWs.

This same problem was originally present for psychiatric disorders. It was only resolved with specific additions to the presumptive list in 1981 and 1984. The Committee, for all of these reasons and more, concluded that expansion of the presumptive list to include certain physical conditions was the only viable approach for modifying an adjudication system that is simply not working for POWs.

Mr. Chairman, before providing specific evidence for each of the proposed physical conditions that would be added to the presumptive list, I would like to comment briefly on VA's reluctance to wholeheartedly support this legislation. We are frankly perplexed since VA spokesmen from 1948 to the present have agreed over and over again that malnutrition would damage body organs with delayed or slowly progressing onset. Also, virtually every involved medical expert around the world from 1950 to the present agrees without reservation that the POW experience leaves such consequences.

We understand VA's concern that medical science has not yet reached the point where a precise etiological pattern can be identified tying malnutrition of the type POWs suffered many years earlier to each specific disease.

But we know—as VA must know—that such precise scientific answers will simply not be forthcoming in the lifetime of most POWs. Under these circumstances, it seems grossly unfair and unwarranted for the VA to continue to impose the following unachievable requirement:

> "The VA will grant service connection...when the medical and scientific communities reach a consensus on a study which is statistically significant, has withstood peer review, can be duplicated, and which finds there is a relationship between the POW experience and the disease or disability." (VA Comment to Recommendation #1, 1983 Advisory Committee Report)

As the POW Advisory Committee has also noted, the application of reasonable doubt to POW claims is meaningless since VA acknowledges it is tied to the individual fact situation. That means medical evidence in the POW's record. Since VA ties "facts" only to what is already scientifically proven in respect to etiology, such facts simply do not exist in POW claims.

VA has also expressed a concern that undeserving veterans might benefit from modifying the adjudication process or adding to the presumptive list. We believe the response of POWs to benefits authorized by PL 97-37 demonstrates they do not take unfair advantage of such benefits. Indeed, the actual cost of adding anxiety states to the presumptive list was only one fourth of VA's estimated costs! Mr. Everett Alvarez, Deputy Administrator—and himself a POW for 8-1/2 years—stated in a taped interview in March 1985 that POWs are creditable, they tell it like it is. And this is exactly what the record shows, POWs do not abuse or exploit their benefits.

Mr. Chairman, I would now like to present specific evidence and information in support of each of the proposed additions to the presumptive list contained in this bill.

## A. CHRONIC LIVER DISEASE

The NAS mortality studies of WWII and Korean Conflict POWs published in 1980 by Robert Keehn found that, beginning with the 10th followup year, there was an excess of deaths due to cirrhosis of the liver among the POW group. This was true regardless of where they were held captive. This finding is consistent with numerous other studies as well as expert opinion in this country and throughout the world.

Liver conditions are known with scientific certainty to result from nutritional deficiencies and unsanitary conditions as were typical of the POW experience. Such damage can be irreversible. Hepatitis was virtually universal in Asiatic POWs, widespread in German camps, and untreated in both despite its life-threatening character.

Statistical data compiled by DVB from October 1, 1981 to December 1, 1984 reveals little or no favorable action on such claims of POWs. BVA data for 1983 reveals the same picture. Both DVB and BVA decisions invariably based their denials on the absence of such diagnosis in the service record and/or the fact that the cirrhosis was not manifested until many years later. They conclude it would be "speculative" to associate present liver conditions with hepatitis that occurred while a POW and add (incorrectly) that "generally accepted medical principles will not support a condition that the veterans' cirrhosis could result from known POW dietary deprivations or unsanitary conditions."

There is great resistance to obtaining outside medical specialist opinions as VA regulations provide. However, in those cases where BVA did accede to repeated requests, that opinion was always supportive of the veteran's claim or clearly establishes a reasonable doubt. For example, in 1982 the hepatologist selected by VA stated:

> "There are no smoking guns for an alcoholic etiology and description of the tissue fits very well with post-necrotic or post-viral etiology...it is inappropriate to state he had no hepatic residuals from his jaundice while a POW." (XC 18 111 187)

A. Chronic Liver Disease (Cont'd)

On this basis, BVA finally did reverse its previous denial action.

Another example,in 1985, BVA (as DVB before it) was unchanged with respect to adjudicating policies. The hepatologist selected by VA stated:

> "liver disease is frequently asymptomatic early in its course and remains so for many years and only becomes symptomatic after development of end-state cirrhosis... the presence of a normal physical examination at the time of discharge (from service) certainly does not exclude significant ongoing liver disease...it would be very difficult to prove the liver disease was not related to possible viral hepatitis that was sustained in WWII." (XC 6 526 064)

This case has not yet been acted on by BVA but responsible medical opinion provided by the veteran was previously rejected and the Board had originally refused to seek such an expert opinion.

In both these cases, which are entirely typical of the substantive issues in POW claims, the process has involved years, not months. In both, the veteran died before resolution and claims were only continued by their widows. A case by case review of DVB and BVA decisions in POW claims of service-connected liver conditions will confirm this testimony.

Even in those cases where there is some evidence of alcohol abuse, that problem is symptomatic of the unresolved psychological trauma resulting from the POW experience. Also, as Robert Keehn, author of the NAS mortality study cited earlier, stated: "it seems likely that a poor diet during captivity might predispose the liver to alcohol damage." There is no record showing POWs were warned of such a danger any time after repatriation.

Conclusion

The inclusion of chronic liver disease as a presumptive condition is fully warranted by scientific and statistical data, supported by expert opinion, and is an effective solution to VA's current inadequate, protracted, costly and unfair adjudication policies.

## B. ORGANIC RESIDUALS OF HYPOTHERMIA

Frostbite was a fact of life for thousands of Americans captured during the savage fighting that took place in the extremely cold winter of 1944-45, primarily during the Battle of the Bulge. It was also true for those captured earlier, particularly servicemen of lower rank. Clothing essential to protect themselves, including shoes, was often taken from them by their captors. They suffered repeated and severe exposure in railroad box cars, long marches, inadequate housing, and/or on work details in fields, mines and the like. Many prisoners in Asiatic camps in Japan and North Korea experienced similar exposure.

The acute symptoms of cold injury were tolerated along with the many other medical problems that characterized the POW experience as a result of the cold, malnutrition and brutality. Release from confinement typically occurred during combat. No examination or treatment was possible for the vast majority at this point or even in the crowded repatriation camps, as "Lucky Strike". As a result, for most it was not made a part of their service or discharge records. While many were granted service connection "by history" in the immediate post-war period, others who had suffered similarly were not.

While there is general acceptance by the military and VA concerning the exposure and hardships experienced—and the occurrence of frozen and frostbitten extremeties, and while veterans can cite personal histories, supported by buddy statements, family members and employers, they face a long, protracted adjudication procedure. Despite this, they are typically denied service connection on two counts. First, the absence of an "evidence of record" in service records. Second, where medical examinations were given, they were limited to observable symptoms (i.e., skin changes, etc.) often not present in residuals of hypothermia.

One case (C 7 611 296) is representative of the time, frustrations and the problems confronting the POW. Unfortunately, like many POWs, he waited until 1973 to file a claim, when the residual symptoms were becoming progressively worse. He had statements from his place of employment from 1945 to the present, first-hand buddy statements describing his frostbite, family member statements, and the like. His service file was not available, presumably destroyed in the record center fire of some years ago. Despite all of the documented information the veteran provided, his claim was denied not only by DVB but by BVA in 1975, 1977, 1978 and 1980. In fact in 1980, the Chairman, BVA, took the extraordinary step of writing the veteran two letters. He stated "BVA and VA are obligated to consider claims...with a great deal of care...laws are interpreted quite liberally...however, the evidence (of record) must support the claim... the objective medical evidence indicates some claims (i.e., frostbite) were not medically recorded until more than a quarter of a century after your separation from service...you have submitted a considerable number of lay statements...however, in all candor, it would appear the question of your entitlement for frostbite of hands, ears and feet...are settled...the post-service medical evidence fully supports the conclusion that your disabilities did not begin in active service."

In late 1983, after at last employing an outside medical expert, BVA concluded that "new evidence" provided a basis of service connection. It should be noted the veteran had been concurrently treated by VA physicians for many years for "severe frostbite". After a very careful and thorough review, the expert stated in unmistakable terms: "it is evident from the record Mr._____ had severe frostbite with damage to subcutaneous tissues... it is important to note there was exposure to cold over a longer period of time than the episode of freezing... Mr._____ had cold injury of the hands and feet...that was certainly severe...he continues to exhibit all of the common symptoms..."

Only at this point did BVA conclude the condition was indeed service connected. Despite all the medical evidence and lay information he was then found to be 0% service connected! After strong protest, this was raised to a token 10% in 1985 and a further increase is under consideration as a result of Congressional concern about the fairness of treatment accorded this veteran. No final decision has been reached.

More than 10 years, thousands of dollars cost to VA, and great frustration to a deserving veteran have transpired in this case. It is repeated many times over with other POWs. It should be understood the substantive issues are the same. DVB statistical data from October 1, 1981 to December 1, 1984 does not provide a specific breakdown for residuals of cold injury. However, BVA data for 1983 shows that only 2 of 17 appeals were allowed.

### Conclusion

The occurrence of cold injury is beyond question in thousands of POWs. Yet they must "prove" the

B. Organic Residuals of Hypothermia (Cont'd)

service-relatedness in each case in protracted hearings and proceedings despite inadequate or nonexistent individual service medical records. Since ratings, if granted, rarely exceed 10%, it is both fair and cost effective to categorize organic residuals of hypothermia as a presumptive condition.

## C. GASTROINTESTINAL DISORDERS

The grossly inadequate diet, persistent stress, spoiled or rotten food, and general unsanitary conditions combined to produce severe gastrointestinal upset in every POW. During captivity, chronic and severe diarrhea and continuing gastritis were inescapable. POWs were repeatedly warned in such repatriation centers as "Lucky Strike" that their stomachs were damaged and considerable care was essential to promote a return to normal. While many POWs did achieve effective recovery, many others did not.

A sizeable minority of the POW population have experienced a continuation of their symptoms after return. However, unless repatriation or separation examinations identified a specific disease process (as an active ulcer), these POWs were invariably described as "normal". The presence of continuing general gastric symptoms was recognized by examining physicians but not found suitable for diagnostic labeling. In many instances, the POWs' gastrointestinal problems gradually worsened ultimately resulting in a peptic or duodenal ulcer, chronic colitis, or some other specific GI condition.

Even though the POW had continuity of gastrointestinal symptoms that were treated for many years by self-medication or private physicians, adjudication panels and BVA Boards have typically denied service connection when such a condition is diagnosed at a later time. DVB statistical data on POWs from October 1, 1981 to December 1, 1984 reflects the high number of claims and a high denial rate. BVA data for 1983 is comparable revealing only one of 55 appeals was allowed.

The reasons for denial include the following:

> "it would be conjectural to hold that ulcer disease was present during service even though we don't doubt that he had gastrointestinal problems in service and during the early post-service period. Many, if not most, such disturbances—even of a continuing nature—do not represent ulcer disease." (C 10 392 704)
>
> "Service medical records do not show a diagnosis of an ulcer condition."

C. Gastrointestinal Disorders (Cont'd)

> "Sound medical judgment indicates there is no relationship between psychiatric conditions and an organic ulcer."

> "Service medical records are negative for an organic stomach condition."

In practice, service connection requires a firm original diagnosis of an organic disease in the service medical records. Continuity of gastric symptoms are summarily discounted if acknowledged at all. The gradual process preceding the emergence of an ulcer is categorized as distinct from ongoing, oft-reported symptoms of gastric distress even though pre-ulcer symptoms are indistinguishable from those typically reported by POWs.

The continued insistence by rating panels and BVA Boards that current medical knowledge does not support a relationship between stress and later organic pathology is in contradiction to general medical care as practiced in VA and elsewhere. For example, Dr. Harold Morris, Senior Medical Clinical Coordinator for Ex-POWs for District #26, stated the following at the VA's National Former POW Education Conference in March 1985 on the basis of 380 carefully evaluated POW medical protocol examinations.

> "...our evaluations indicate the profound degree of anxiety and depression presents...peptic ulcer disease with all of its manifestations and complications."

The supportive opinions of private physicians and VA treating physicians concerning the etiological relationship between the POWs continuing stomach problem and the eventual occurrence of an ulcer is almost invariably rejected.

Conclusion

POWs are routinely denied service connection for gastrointestinal disorders on the unfounded basis of no etiological relationship between gastrointestinal symptoms beginning as a POW and continuing down to the present unless the diagnosis of an organic condition had been made during service or within a two year period after discharge. Instead, a separate seemingly parallel process is inferred. Nor is continuing emotional stress, even when diagnosed, accepted as a factor causing or contributing to the later

C. Gastrointestinal Disorders (Cont'd)

organic pathology. The high incidence of organic conditions in POWs with such histories has been documented by extensive POW evaluation programs in such VA Medical Centers as Loma Linda, California.

Establishing gastrointestinal disorders as a presumptive condition is fully warranted by the total picture, supported by treating physicians, in and out of VA, and urgently needed by POWs.

## D. ARTHRITIS

Skeletal disorders, including arthritis, represent a major area of disability for POWs. It is also the area with the greatest number of denials according to the DVB statistics from October 1, 1981 to December 1, 1984. BVA data for 1983 shows that only 2 out of 45 appeals for service connection of arthritic conditions were allowed.

POWs are known to have experienced extensive physical trauma at the time of capture and throughout confinement. Airmen escaping from destroyed aircraft were subjected to not only the normal whiplash injury resulting from the opening of parachutes but to also numerous injuries to backs and extremeties as a result of landing at night often after a low-level bailout on frozen ground in a semi-conscious state. Under these circumstances, they were totally unable to protect themselves from injury. After reaching ground they were subjected to further trauma from captors who typically struck them with rifle butts or other large objects.

Similarly, ground forces were subjected to extensive trauma due to exploding shells, mortars and bombs rendering them unconscious or unable to protect themselves. After capture, they, too, were subjected to much physical injury to their bodies by their captors. Savage beatings and injuries also characterized the POW experience.

Injuries not only occurred at a very high rate but were typically untreated or, where treated, were given very limited and crude care. Despite the array of traumatic injuries suffered, POWs were forced to march long distances, subjected to hard labor, exposed to the cold and the damp, and kept in cramped boxcars, cells or other circumstances damaging to their bodies.

In addition, the extensive and severe malnutrition has been shown by authoritative medical studies to result in osseous, cartilagenous and collagen degeneration.

The extensive and detailed clinical studies done on 380 POWs from the Protocol Medical examination at VAMC Loma Linda have confirmed a high incidence of degenerative joint disease and of osteoporosis occurring at a relatively young age. These findings are duplicated by similar examinations done at other VA facilities.

## D. Arthritis (Cont'd)

While the evidence for trauma resulting in lasting and/or progressive arthritic disorders is overwhelming, claims of POWs are typically denied on the basis that the service medical records (known to be inadequate, if existing at all) do not show evidence of the condition claimed. If the injury is accepted as fact, denial still occurs on the basis that there is no evidence to show that the injury resulted in permanent damage.

The fact that the circumstances under which the veteran was captured (i.e., bailout and landing on frozen ground) would support the veteran's claim, buddy statements concerning the injury, are considered inadequate in the absence of medical records of injury and treatment in service. Even though arthritis is known to occur as a consequence of prior trauma that can gradually develop and worsen, tying this to even severe trauma as a POW is considered too "conjectural" to be given consideration. A case by case review of VA claims and appeals action will confirm this statement. Later claims based on earlier injuries are summarily denied.

## Conclusion

Almost all claims for service connection for arthritis, traumatic or degenerative, are currently denied by DVB or BVA. The circumstances of capture, the general knowledge about damage that can occur or result from those circumstances, the damage done to musculo-skeletal due to malnutrition, first-hand accounts of injury supported by buddy statements—none of these factors balance VA decisions based on "medical evidence in the record" or the incorrect assumption that requests for service connection some years after return to service reflect evidence of no permanent injury. With high incidence of such injuries and the inadequacy of current VA procedures to reach any favorable decisions under circumstances described, the only viable option for these deserving veterans is inclusion of arthritis in the presumptive conditions.

## E. CARDIOVASCULAR CONDITION

Extensive research from 1945 to the present has identified major risk factors contributing to arteriosclerotic heart disease. Diet, stress, exposure, injury, disease, dehumanization, and other destructive forces known to characterize the POW experience are all recognized as contributing adversely to the maintenance of health or to life itself. These factors, acting in combination and in the absence of supporting factors present in non-POW situations, are known to have permanent consequence. Are there any serious doubts that the starved bodies of African adults and children will result in shortened life and impaired health? Common sense as well as general medical knowledge tells us beyond a reasonable doubt that such damage will be present.

The severe nutritional deficiencies experienced by POWs, including beriberi, in the context of the other adverse factors, constituted a major destructive force on the bodies of survivors. In this respect Gilbert Beebe, author of the 1975 report of the NAS followup studies of morbidity in POWs, suggested that survivors may even have been of better-than-average physical constitution and emotional stability. Despite this likelihood, disease rates and periods of hospitalization are greater.

The examination and evaluation of 380 POW medical protocols by VAMC Loma Linda is representative of similar efforts in other VA health care facilities. Dr. Harold Morris, Senior Medical Clinical Coordinator for Ex-POWs for DM&S District #26, provided very substantial documentation for enduring damage to POWs, particularly in cardiovascular functioning. In addressing the DM&S National Former POW Education Conference, held in Dallas, March 5-6, 1985, he said the following:

> "I have been impressed with the fact of the high priority (frequency) of specific disease entities of life-threatening nature in former POWs...the chronologic age...is an average of 63-65 years of age... (but) the degree of degenerative diseases, supplemented by lack of family history supporting an evidence of premature aging, puts the physiologic age at an average of 71-73 years."

E. Cardiovascular Condition (Cont'd)

He went on to further state:

> "In our groups, both Japanese captives and European captives, there is a profound evidence, as high as 80%...of arteriosclerotic heart disease, predominately occlusive disease...however, this is not limited to ischemic heart disease but rather we have found a very high incidence of carotid occlusive disease...in addition to peripheral vascular occlusive disease, with claudication...time is running out for the WWII POWs and although it's not surprising...this places the... physicians' concern primarily upon prompt and definitive assessment and treatment."

## Conclusion

Although these intensive studies confirm the judgment of numerous other experts in POW health consequences and the trend found in NAS longitudinal studies, claims for service connection are routinely denied by DVB on the basis of lack of medical evidence in the record, passage of time between POW experience and incidence of heart disease, and absence of a demonstrated etiological process in the individual case. Appeals to BVA rarely change this outcome. BVA statistics for 1983 show only 3 of 69 appeals were approved.

Inclusion of cardiovascular condition in the presumptive list is justified on the basis of the factors and facts presented in this testimony.

## F. PERIPHERAL NEUROPATHY

This condition was known to be prevalent during captivity as a result of nutritional deficiencies and/or damage to tissue and nerve-endings due to cold injury. Permanent and/or progressive damage is not unexpected.

DVB adjudication action and BVA appeals have not been favorable and have imposed impossible requirements upon POWs in terms of evidence in the record and precise etiological processes. Neither provide statistical data specific to this area but include it in broader categories. Detailed discussion contained in previous sections apply and need not be repeated here. Case-by-case review of DVB and BVA actions will confirm the very high denial rate.

### Conclusion

POWs are confronted with a high incidence rate for this problem but existing VA rules and regulations preclude the approval of these claims. The inclusion of peripheral neuropathy in the presumptive list is warranted and supported by all medical experts knowledgeable in POW health problems.

## G. IMMUNOLOGICAL DYSFUNCTIONS

There is increasing current evidence of immunological deficiencies resulting from stress. Similarly, there is growing evidence that severe nutritional deprivation can play a significant role in depleting or damaging the capacity of the human body to resist destructive disease processes. These include infectious disorders, allergies, auto-immune disease, and neoplastic diseases. The POW experience, by a potent combination of stress and nutritional factors, is believed by many knowledgeable experts to cause such damage to immunological capacities.

The VA Study of Former POWs published in 1980 acknowledges that POWs have a higher incidence and greater variety of diseases attributable to the POW experience. Dr. Harold Morris noted from the 380 POW medical examinations completed at VAMC Loma Linda that the incidence of primary neoplasm in the overall group of POWs is "alarming". His medical colleagues believe that malnutrition and loss of immunocompetence is a major factor, particularly with respect to pulmonary disease. The possibility that premature aging is a reflection of impaired immunological functioning is also suggested.

### Conclusion

The evidence supporting immunological deficiencies in POWs comes from many different sources but is persuasive. VA adjudication rules and regulations do not offer any means for addressing this problem. Its manifestation is most evident in POWs confronted by a variety of life-threatening but seemingly unrelated disease processes, usually occurring at an earlier age than normally associated with "declining health". The inclusion of immunological dysfunctions in the presumptive list is the only viable option for POWs with an accelerated pattern of declining health and occurrence of the types of disease processes identified.

## H. CHRONIC PULMONARY DISEASE

During imprisonment lung infections, including tuberculosis and pneumonia, were prevalent. The malnutrition, exposure, physical and mental exhaustion—coupled with forced labor, long marches, confinement in holds of ships or boxcars—produced loss of resistance to disease processes. This is verified by NAS mortality and morbidity studies. The greater vulnerability to repeated pulmonary and pleuritis infections is most recently documented in the 380 POW medical protocol examinations at VAMC Loma Linda.

POW claims in this area, except for TB, are routinely denied on the basis that pulmonary problems experienced while a POW were transitory; therefor, unrelated to current chronic pulmonary problems. Yet POWs frequently show a pattern of repeated lung problems resulting in chronic pulmonary disease. Loss of resistance (loss of immunocompetence) is an underlying factor. Case-by-case review of POW claims will substantiate this as do DVB statistics from October 1, 1981 to December 1, 1984.

### Conclusion

Chronic pulmonary disease is a significant problem, one that is not effectively addressed by current adjudication policies and regulations. In view of the documented vulnerability of many POWs to chronic lung disease, including this as a presumptive condition is fully warranted.

Summary

Mr. Chairman, in conclusion, we believe the total record of post-service adjustment of POWs overwhelmingly confirms the conclusion that this imprisonment resulted in diverse and severe later health damage. This was predicted by Congress and VA, repeatedly verified by research here and abroad, and is unequivocally acknowledged by physicians with expertise in this area everywhere.

The latest of these studies we have repeatedly cited in our testimony. It is the evaluation of 380 POW medical examinations conducted at VAMC Loma Linda. However, it does not stand alone. Charleston VAMC and many other fine VA facilities are conducting the same examinations—and reaching similar conclusions. We are particularly impressed, and reassured, by the fact that physicians in VA facilities who become directly involved in POW health matters have few reservations about the permanence and variety of health problems resulting from the POW experience. We are also grateful for the fact that these fine professionals grow to perceive POWs as very worthy and deserving veterans who served their country heroically.

Mr. Chairman, we understand and support the desire of the

VA to identify the precise etiological pattern between the POW experience and specific disease entities. Nevertheless, we do not believe this worthy scientific objective can continue to justify further delays, particularly in view of the age of these veterans and their long postponed benefits.

We believe, as does the POW Advisory Committee (after three years of intensive study) and a growing body of VA physicians throughout this country, that a significant medical consensus now exists in support of the conditions proposed for inclusion on the presumptive list.

We reluctantly call to your attention that, in the 3-1/2 years since the passage of PL 97-37, DVB has yet to make a single definitive change in regulations governing the adjudication. It is true that adjudication staff has been urged to give POWs the "benefit of the doubt" yet it has not instructed them how to do so. Reasonable doubt remains firmly tied to available medical "evidence" when such evidence is grossly inadequate or non-existent for POWs. The decisions, and reasons for those decisions, remain precisely as before PL 97-37 was enacted.

Finally, Mr. Chairman, we are keenly aware of budget constraints. We believe that the cost of this legislation will be far less than VA estimates. We call to your attention that VA estimates for PL 97-37 were four times greater than actual costs. We further call to your attention the fact that there are important offsetting costs. POW claims, appeals, and reviews take far longer time than the single-event approach utilized by VA. The time before there is resolution of a claim is many years and many thousands of dollars in administrative and professional time. This is far from cost effective since 71% of favorable adjudication action on some 14,000 adjudication action on POW claims during the period October 1,1981—December 1, 1984 were at the 0% or 10% level and only 19% were at the 30% level.

But, more important, Mr. Chairman, we believe the American public recognizes the incredible sacrifices POWs made for their country—and will wholeheartedly approve of this legislation.

Thank you.

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WRITTEN TESTIMONY OF
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WITH RESPECT TO DISCUSSION
OF
VETERANS STIPEND LEGISLATION
s 1536

Mr. Chairman, Members of the Committee on Veterans Affairs:

We are delighted to have this opportunity to provide written testimony in support of Senate Bill 1536 concerning the Veterans Per Diem Stipend as it applies to offsetting medicaid costs for veterans placed in State Veterans Homes.

Before beginning to address this specific issue, we would like first to take just a moment to express our appreciation and that of all veterans in the Great State of Maine for the ongoing efforts of Senator George Mitchell on behalf of America's veterans. Senator Mitchell has carried the serious concerns of veterans here in Maine, particularly as they relate to health care, to the attention of the United States Congress, and we are most grateful for his assistance and the continued support of our congressional delegation.

We would like also to explain the nature of our organization, the Aroostook county Veterans Medical Facility Corporation and why we feel it appropriate for us to speak, in one voice, in support of veterans health care issues.

The organization was formed more than seven years ago. The organization is made up of veterans representing various service organizations. We are honored to have within our organization a recipient of the Congressional Medal of Honor, former prisoners of war, and disabled American veterans. Veterans of Foreign Wars, American Legion, Marine Corps League, and Disabled American Veterans all are represented formally within the organization.

The chief focus of the organization is to advocate for more locally available health care services for veterans living in remote areas of our State and nation. The organization is completely voluntary. Members of the organization travel on a monthly basis to attend regular meetings. Many of our members travel 50 to 100 miles, at their own expense to attend such meetings. The organization has received financial support from various posts and veterans organizations in Aroostook County. We feel very comfortable commenting on the Stipend Legislation, particularly considering the important stake Maine's aging veterans have in the resolution of this issue.

Maine is one of five states, which, thru State Legislation, finances costs for providing care in State Veterans Homes, thru the medicaid Program. Laws, as currently written, force the State to consider the veterans per diem stipend as a third part liability. Therefore, the stipend must be factored into the medicaid formula offsetting any additional financial value in providing operational monies critical to the successful development of a high quality program.

The issue raised in S 1536 concerning the Veterans Stipend is most critical to veterans here in Maine at this time. The Maine State Legislature in its most recently completed session, passed legislation authorizing the establishment of two additional nursing homes for veterans in northern Maine and southern Maine in order to meet the demands of the aging veteran population in need of such care. The northern Maine home will be constructed here in Aroostook County. Governor Joseph Brennan signed this legislation into law, representing a great achievement for many of Maine's veterans who have been working so diligently over the past several years to secure such legislation.

Aroostook county is one of the most rural and remote areas of our country. The county has a land mass greater than 6500 square miles, larger than the states of Rhode Island and Connecticut combined. Within this massive land area live some 95,000 people. More than 12% of this population are veterans.

A recent study completed by the Veterans Administration, a study secured through the efforts of this committee, noted that Aroostook County was one of twenty counties in this nation that is 200 miles or more distant from a V.A. Hospital. The only such county with this distinction east of the Mississippi. In contrast, more than 97% of veterans in this country live within 100 miles of a V.A. Medical facility.

The fact is that the center of Aroostook County, Caribou, Maine, is 500 miles round trip distance to the Togus V. A. Hospital in the State capital, Augusta. Augusta is also the location of Maine's only Veterans Home in existence at this time. Putting our location in more perspective, Caribou is 300 miles round trip from Bangor, Maine, generally considered the northern tip of the State of Maine.

In addition to the remoteness of the area, severe weather conditions for several months out of the year and the lack of interstate highway, make travel an often precarious proposition. Public transportation is also extremely limited.

This material is presented to you to suggest the rural nature of Aroostook County and the need for the development of a centralized nursing home facility in the region. The passage of State legislation has opened the door for the development of this project, however the veterans stipend is also a critical consideration.

The Maine legislation has created an opportunity to construct up to sixty nursing home beds that could help meet the needs of Aroostook County Veterans. The Maine Veterans Home program, using a unique approach to the development of the facility would not intrude upon the Veterans Administration Nursing Home Construction Budget but would construct the facility using conventional financing. The construction of the facility, given its limited size, could be done in a most cost effective way using such conventional financing. However, from an operational standpoint, the veterans stipend is most important.

Passage of S. 1536 would allow the per diem stipend to be excluded from consideration as a third party liability for those states financing care in veterans homes thru the medicaid program. The $17.05 stipend could than be used in the development of a high quality facility that would provide the level of care deserved by veterans who are in need.

Without stipend monies our home would be a purely medicaid level facility. Programs that we are considering, including geriatric teaching programs for medical residents, nursing education programs coordinated with various area universities, and other teaching programs would be in jeopardy without stipend funding. A dynamic teaching nursing home concept, providing extensive physician medical interaction with patients and staff is also a key element in this program that desperately needs the additional funding made possible by the per diem stipend. Exceptional levels of quality care and the advantages of additional training in geriatric medicine for physicians and other health care professionals is at the heart of the Maine Veterans Home program. The $17.05 stipend would be such a minimal cost to generate such a valuable program. This is even more reasonable considering that the State Veterans Home program has shown itself to be the most cost effective method of providing nursing home care to veterans.

We have not touched upon the fairness of this issue. The veterans per diem stipend was designed by Congress as a benefit to veterans who have done so much to preserve this nation and who find themselves needing nursing home care. Under current law, this benefit is virtually non-existent. Veterans have certainly earned the level of care provided by the State Veterans Home program and the stipend was created to provide it.

It was veterans from remote areas of this land that heeded the call in superior numbers when our nation needed them. Aroostook County is a prime example of that patriotism. The State of Maine itself ranks 5th in this nation per capita in its population of veterans. Veterans do not want something they have not earned. The stipend is rightfully theirs.

The age of America's veterans, as we know this committee is ware, is rapidly increasing, similar to our overall population. World War Two veterans are now at an age where they will have significant impact on all segments of our nations health care system and our Korean War veterans are on the threshold. The State Veterans Home program represents the most cost effective way of providing nursing home care to these veterans.

The Aroostook County Veterans Medical Facility Corporation, for which we are proud to serve, has been in the forefront of efforts to provide more locally available health care services to veterans living in remote areas. We have now taken a major step, here in Maine, to provide for one important aspect of that goal, the State Veterans Home here in Aroostook County. We firmly believe that it was the original intention of Congress that the stipend assist veterans homes to establish a high level of quality care and programs for which, as a nation, we can be proud. The success of the State Veterans Home program is well documented. We urge this committee to look favorably on S. 1536 and return the stipend to its rightful place. We appreciate and are grateful for the opportunity to address this most important issue.

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## WRITTEN QUESTIONS FROM CHAIRMAN MURKOWSKI TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

Question: 1. What is the status of your efforts to follow-up to the recent Inspector General report concerning fee-basis care in Alaska and what is the next step in those efforts?

a. What is your time frame for the resolution of these issues.

Answer: The control of fee-basis is directly related to the issue of an outpatient clinic being established at Anchorage. The Department of Medicine and Surgery has developed a plan for establishing such a clinic. This plan is currently under review within the Agency.

When a decision on the plan for the outpatient clinic is finalized, the Department of Medicine and Surgery will arrange for a briefing of the SVAC staff. It is anticipated that this briefing will occur late summer or early fall.

Question: 2. What specific administrative steps would you have to take to use Medicare fee schedules when making payments to the private sector for services provided to veterans?

Answer: The question encompasses a two-fold issue. DM&S has examined the potential use of Medicare outpatient fee schedules and has determined that adoption of the same or a similar system would be very cumbersome and administratively difficult. The Medicare Part B system is administered by a large number of contract carriers in various parts of the country. Each of these carriers is charged with the responsibility of determining when to pay 80% of reasonable charges for covered services after a deductible has been met by Medicare beneficiaries. The determination of such charges is both provider and location dependent and is limited by enabling legislation and Health Care Financing Administration regulations. For the VA to link up with this system would require countless contacts with scores of third party carriers and would not allow the VA to adopt VA practices to circumstances unique to the Veterans Administration. DM&S has enough data in its outpatient fee programs to develop outpatient fee screens based on VA experience. For inpatient charges, the VA plans to use Medicare allowable DRG payment rates as the basis for payment. Although this has the potential for being fairly difficult to administer, there does not appear to be an alternate method for capping VA's obligations for payment of private inpatient care.

Question: a. How much would it cost you in administrative expenses?

Answer: Although no cost analysis has yet been performed, it is anticipated that the administrative expenses will be minimal.

Question: b. How much time would it take to put these fee schedules in place?

Answer: Payment at the Medicare allowable DRG rate for inpatient care is to be effected during FY 87. Due to the software requirements of the fee outpatient system, it is not possible to predict with any accuracy the cutover timetable for the outpatient system.

Question: c. What difficulties do you anticipate in implementing the fee schedule?

Answer: No significant difficulties are expected in implementing these initiatives. These efforts compete with other priorities for development, though, and it is this competition which would slow implementation.

Question: d. How do you expect physicians to respond to this policy and administrative change?

Answer: As most third party payors and other insurers have taken steps to limit payments, no significant adverse response is expected.

Question: e. How would these fee schedules take into account regional differences in health care costs, such as higher costs in Alaska?

Answer: The outpatient fee schedule would be a percentage of the billed charges and as such it would reflect the higher costs of Alaska. The inpatient allowable DRG rate will reflect an average of national experience with costs.

Question: 3. In 1985, the Health and Human Services Department permitted States, under Medicaid, the Federal-States medical benefits program for the poor, to cover home and community-based services as an alternative to institutional care. How do you reconcile your position on the Chairman's health-related services provision vis a vis the Administration's policy concerning Medicaid?

Answer: The addition of health-related services to the array of medical services already provided by the Department of Medicine and Surgery would greatly expand the mission of the Department. As we stated in our May 20, 1986 testimony, the Congressional mandate for the Department (38 U.S.C. Section 4101) "contemplates that VA will provide veterans with all needed medical services, either in VA operated facilities, or in limited circumstances when necessary, in facilities for which the VA contracts." The provision of health-related services, especially homemaker and chore services, does not constitute medical services.

We recognize the value and the popularity of health-related services in local communities. States have added these services as a regular Medicaid benefit or through the Medicaid Waiver Program. At the same time, the research, largely funded by the Department of Health and Human Services, does not support the idea that health-related services can substitute for institutional care.

The Department of Medicine and Surgery has supported the establishment of alternatives to institutional care with a medical orientation. In the past two years, the Department has established 19 new Hospital Based Home Care Programs and six Adult Day Health Care Programs, each with strong health care components. The authorization for Adult Day Health Care in Title 38 explicitly requires a medical orientation which is consistent with the Agency's existing mandate.

Currently, the Department relies on community-based services to provide health-related and social services through a referral network. We find this system of the VA providing health care services and the community providing health-related and social services to be effective in meeting the needs of veterans.

Question: 4. The Geriatrics and Gerontology Advisory Committee (GGAC) recommends that the VA expand its hospital-based home care (HBHC) program to be able to contract for those services as well as to provide them in house. The fiscal year 1987 budget request notes that legislation to contract for HBHC will be proposed.

a. Your testimony stated that Section 3(a) of S. 2445 providing this authority is too broad. However, according to the GGAC's December 1985 report (p. 23) the services to be provided — medical, rehabilitative, social, and nutritional — are those very services currently being provided by the VA's in-house HBHC program. How do you explain your concern that these services are too broad when your own program is providing the very same service?

Answer: The Geriatrics and Gerontology Advisory Committee (GGAC) report of December 1985 describes Hospital Based Home Care (HBHC) as providing an array of health services including nursing care under the supervision of a professional nurse, rehabilitation therapies, medical social work services and dietetic consultation on nutritional needs under the direction of a physician. The services required by the patient are identified by the physician and furnished in accordance with the patient care plan developed by the HBHC team under the leadership of the HBHC physician. Eligibility is limited to patients discharged from the hospital who are in need of follow-up medical services which can be provided in the home. The diagnostic procedures and medical workup required are completed during the course of the hospital stay. When a specialty consultation or a diagnostic procedure is required, the patient is returned to the outpatient clinic using beneficiary travel. Social support services such as homemaker, nutritional services (meals on wheels) and transportation to community senior centers are not authorized under this program. These non-medical support services are secured through resources in the community or other benefits. Expanding the services of HBHC to include social support services is a departure from the longstanding policy that the Department of Medicine and Surgery be responsible for medical services to veterans and that other needs be met by resources in the community or other benefits.

The closest existing program for contract purposes would be the Medicare Program. A comparison of the two programs is shown below:

Comparison of Covered Services

| Medicare Home Health Services | VA HBHC |
|---|---|
| 1. Medical services covered under part B and provided by the patient's physician in his office. | 1. Medical Services provided by a physician assigned to the HBHC program. |
| 2. Professional nursing services | 2. Professional nursing services, including geriatric nurse practitioners. |
| 3. Physical, occupational, or speech therapy. | 3. Physicial, occupational or corrective therapy. |
| 4. Medical social services | 4. Medical Social Work services. |
| 5. Part time or intermittent services of a home health aide | 5. Nursing Assistant services. |
| 6. Medical supplies, other than drugs, or biologicals, and the use of medical appliances. | 6. Medical supplies, including drugs and biologicals and the use of medical appliances. |
| Source: 42 USC 139x(m) | 7. Nutritional counseling. |
| | 8. Home adaptation. |
| | 9. Consultation by clinical pharmacist. |
| | 10. Specialized procedures and consultation by medical specialists. |
| | Source: 38 USC 612(a) (f) and M-1, Part I, Chapter 30. |

Question: 4b. For which categories of veterans would you recommend that the VA provide HBHC services on a contract basis?

Answer: We would recommend that HBHC services on a contract basis be authorized to veterans following a period of hospital care to obviate the need for nursing home care. In this manner the patient will have had a complete diagnostic workup, assuring the provision of appropriate medical care through followup services in the home. The need for return trips to the hospital for diagnostic testing or treatment procedures will be minimized.

Question: 4c. Are there circumstances when at home or in a contract facility, visiting psychiatric services would be beneficial and cost-effective in responding to varied health-care needs and in keeping a veteran from needing hospitalization?

Answer: There are many instances when the provision of mental health services to veterans residing in a home would be both therapeutically beneficial and cost effective in responding to the varied health care need of veterans with psychiatric disorders. In addition, provision of mental health services in the veterans' residential settings (including alternative care residential settings) should result in less frequent hospitalizations and shorter lengths of stay when hospitalization is required.

Clinical experience and formal research have conclusively demonstrated that traditional hospital bed-based programs and traditional outpatient programs are limited in their responsiveness to many of the treatment needs of chronic, severely disabled and elderly psychiatric patients.

The development of a comprehensive system of psychiatric care for veterans requires activation of innovative alternative care programs that emphasize treatment in the community whenever possible. Within this context, the development of crisis intervention teams, mobile community treatment teams and elderly support teams provide the foundation for creating an aggressive community-based system of psychiatric care.

* Mobile Community Treatment Teams (MCTTs) for psychiatric care should be developed to parallel the VA's highly successful Hospital Based Home Care (HBHC) programs for medical and surgical care. These MCTTs can provide periodic prolonged treatment for psychiatric patients who are relatively stable in the community. The tasks of these units will be to pursue patients who are non-compliant with treatment, to assertively effect necessary medical treatments and to realign the essential residential, social and familial support systems.

* Crisis Intervention Teams (CITs) should be developed to provide psychiatric treatment of severe and unexpected decompensations in the community setting. These CITs can provide emergency psychiatric treatment wherever the patient lives. The staff on such a team would be available within geographically reasonable limits to visit former patients who are experiencing serious acute problems which require immediate attention and for which a trip back to the hospital is not in the patient's best interest.

An example of this might be a former patient discharged from one of our wards who is living in an unsupervised group home and who suddenly decompensates following the visit of a relative. Traditionally, the patient would be required to return to a VA mental health outpatient clinic for treatment. However, with severe and unexpected decompensation, the patient is probably not able to organize his/her thoughts well enough to manage the trip to the outpatient clinic. Decompensation may continue to the point when the patient is totally immobilized and only receives treatment if others respond to his/her therapeutic needs and returns the patient to the VA medical center for care. In extreme cases, the patient might commit suicide. Under this new proposal, a crisis team would be called by the patient or someone close to the patient and the team would go to the patient immediately to help contain the disturbance by whatever means are indicated.

* Elderly Support Teams (ESTs) should be developed to provide on site support and treatment to veterans with psychiatric disorders in community residential care facilities. These ESTs can provide consultaion to staff on the management of older veteran patients with psychiatric disorders. These teams can also facilitate the transfer of psychiatric patients back to the hospital for brief periods of hospitalization, when needed, and facilitate the patients' subsequent return to other residential programs following their brief periods of hospitalization.

It is important to remember that the three functions described above may be performed by the team of VA professionals. The VA is currently exploring the desirability of providing visiting psychiatric services to veterans in contact nursing homes and other institutions.

Question: 4d. Are psychiatric services provided as a part of HBHC? If not, why not?

Answer: In FY 1985, patients with a primary psychiatric diagnosis comprised 4.3 % of all admissions to HBHC. However, 27.7% of the HBHC population have a secondary or other psychiatric diagnosis and have a primary diagnosis of a chronic medical problem.

Because of the multiple, interacting disease processes which typify the aging patient, it is important that collaboration and consultation between internists, oncologists, etc. be maintained with psychiatrists and other mental health professionals. Psychiatric services are not included in the primary services offered to patients in the currently structured HBHC programs. This is reflected in the program guidance, criteria and standards for HBHC programs and in the makeup of the assigned professional staff. Altering the mix of the HBHC staff to include psychiatrists and other mental health professionals within the HBHC core staff should enhance the capabilities of the existing program to meet the needs of patients whose secondary health problems are psychiatric.

In addition to enhancing the capabilities of existing HBHCs to address the psychiatric needs of a primarily medical patient population, there is an additional need to develop psychiatric community treatment teams to provide treatment of patients whose primary health problems are psychiatric. This program concept is more fully developed in the answer to question 4c.

Question: 5. Last August, the Senate Appropriations Committee directed the VA to "immediately promulgate a program by which parking facilities can be provided at VA medical center sites and the costs paid for or amortized by the charging of user fees." The Committee also expressed its intent to expeditiously consider authorization for such construction when a fee-based cost-recovery system is implemented.

a. What is the status of the VA's efforts to promulgate such a program and what are the preliminary recommendations?

Answer: A VA task group was convened to develop alternatives for implementing a paid parking program. As a result of this effort, a position paper which sets forth a general structure for such a program has been prepared. The Administrator is in the process of reviewing the position paper and will make a determination on preliminary recommendations in the near future.

Question: 6. Since the VA currently has the authority to establish and collect reasonable fees for parking at VA medical centers:

a. Why hasn't the VA established such a system yet other than in two locations?

Answer: The VA, along with other Federal agencies, instituted a nation-wide pay parking program in August 1979. At that time the VA elected to use its statutory authority under title 38, section 5009, as the basis of collecting fees rather than the directives of OMB Circular A-118. As a result, the VA's pay parking program was not directly impacted by the subsequent U.S. District Court ruling which invalidated the continued collection of fees by other Federal agencies. The VA, however, suspended the collection of parking fees after considering the negative effects on employee morale if such a program were to continue subsequent to the Court's ruling.

Question: b. Does the VA intend to establish such a system in the immediate future based on its current authority?

Answer: We recognize from our efforts to win support in Congress for needed parking facilities that there is strong sentiment that persons using those facilities should at least, in part, contribute towards the cost of those facilities. Accordingly, we will develop procedures to implement a paid parking program under VA's existing authority to impose parking fees based upon the Administrator's determination referenced in the response to question 5.

Question: c. If not, please explain the reasons for not doing so.

Answer: We will develop procedures to implement a paid parking program under VA's existing authority to impose parking fees based upon the Administrator's determination referenced in the response to question 5.

Question: 7. If a parking facility provision similar to Section 303 of S. 2422 is enacted:

a. What initial amount do you believe would be necessary to appropriate to the revolving fund to enable VA to finance the construction, alteration, acquisition and operation and maintenance of parking facilities currently planned for VA medical centers?

Answer: Estimated appropriations for construction, alteration, acquisition, operation and maintenance are as follows:

FY 1987 - $19,954,200
FY 1988 - $22,060,600
FY 1989 - $ 7,688,975
FY 1990 - $ 7,005,100
FY 1991 - $ 6,443,080

The costs presented above represent our best estimate of funding requirements to construct additional structures and to maintain and operate all VA parking. In developing these figures VA has taken into account revenues which would be derived by collecting fees at those facilities receiving new structures. However, in estimating collections, VA assumed that no fees would be charged for parking in existing VA parking spaces (fees would only be collected for parking paid for though the fund). If parking fees were collected for all existing VA parking, substantially greater collections would occur and the need for funding would decrease.

Funding requirements for Fiscal Years 1987 and 1988 are significantly higher than later years due to the construction of previously planned parking structures. If fees are collected after these structures are activated, the need for additional appropriations would decrease as collected fees begin to offset costs and the need for new structures is diminished.

VA does not, however, support use of a revolving fund as the vehicle for funding the maintenance, operations and construction of VA parking facilities.

Question: 8. Concerning the establishment and implementation of reasonable fee schedules for paid parking in accordance with the provision in S. 2422 --

a. How would the determination of reasonable fees be made and what criteria would be considered in prescribing fee schedules of situations when it would be mandated and when it would be discretionary?

Answer: Although no final determination has been made, VA is considering a number of options which address the possible fee structure utilizing our current authorities. One possible approach would be to predicate fees on the fair market value of parking under the circumstances provided and also stipulate that fees, whenever imposed, would not be less than a predetermined monthly minimum.

Question: b. What amortization period or periods would be reasonable for the full or partial recovery of construction, acquisition or alteration costs if the VA decides to include such costs when prescribing a fee schedule?

Answer: If an amortization period is prescribed in a fee schedule or formula, VA favors a period which is related to the reasonable life expectancy of the structure or improvement and also related to a reasonable fee level.

Question: c. Please comment on whether each of the categories of individuals who would be subject to parking fees is appropriate.

Answer: As drafted, the bill exempts only vehicles transporting patients for examination or treatment. VA recommends that the exemption be expanded to include vehicles transporting visitors of patients, volunteers, and others providing services with no VA compensation. VA believes that the imposition of fees would constitute an undue burden on families of veterans, on volunteers, and on others who provide a service without compensation.

Question: d. Would it be preferable to mandate and charge uniform fees on a nationwide basis?

Answer: This option is being considered; however, no determination has been made at this time. VA is concerned that charging a fee where adequate parking is currently available would have the appearance of unfairly assessing a large number of people to benefit others who would receive the actual parking benefit.

Question: e. Should geographical cost-of-living variations be considered in prescribing parking fee schedules in both mandatory and discretionary situations?

Answer: VA has made no determination in this area aside from recognizing that the cost of parking will certainly vary in geographical regions if fees are related to the reasonable value under the circumstances provided.

Question: f. Should a separate rate of parking fee be charged for VA surface parking than for parking in VA garage facilities?

Answer: For administrative purposes, VA favors that all parking at a specific VA facility be assessed at the same rate.

Question: g. If the provision in S. 2422 is enacted, which VA medical centers would be affected immediately by the madatory charging of parking fees?

Answer: No VA medical center would be affected immediately since there are no garages to be opened or alterations to be completed on a garage immediately; however, VAMC Philadelphia would be the first to institute mandatory fees under the provisions of S. 2422.

Question: 9. During the VA medical construction hearing which this Committee held on April 10th, Mr. Ivers stated that union contracts presently do not include charging employees for parking.

a. Do any such contracts expressly prohibit charges for employee parking at VA medical centers?

Answer: Three national labor-management agreements expressly prohibit the establishment of parking charges during the duration of the agreements for parking that is currently provided at no cost:

* AFGE Master Agreement: Article 18, Section 1
* NFFE Master Agreement: Article 36, Section 3
* NAGE (non-profit) Master Agreement: Article 36 Section 1

There may be provisions in local contracts for those facilities not covered by the Master Agreements. This information is not available.

Question: b. If so, how many VA employees would be affected by such agreements?

Answer: The agreements cover approximately 125,000 employees throughout the VA, although the vast majority are employed by DM&S.

It should be noted that in those cases where VA facilities have severe parking problems, it is likely that the labor organizations will welcome charges with correction of the problem.

Question: 10. During the construction hearing held on April 10th, the General Counsel interpreted the language in current law (Section 5009) to require an appropriation act to trigger the creation of a revolving fund into which fees from parking at VA medical centers could be deposited.

(a). If the provision in S. 2422 is enacted, in your opinion, would the language require the VA to establish the revolving fund without the need for an "appropriation act" to trigger the establishment of the fund so that fees could be immediately deposited into the revolving fund on October 1, 1987?

Answer: If S.2422 is enacted, the VA would be required to establish a revolving fund and parking fees collected after October 1, 1987, would be deposited into the revolving fund without the need for appropriation act legislation. However, expenditures from the revolving fund would require approval language in an appropriation act.

Question: (b). What, if any, problems do you anticipate in administering the revolving fund?

Answer: In general it is our view that use of the revolving fund as the basis for operations, maintenance, and acquisition of all parking facilities constitutes an undue administrative burden with little benefit for the time invested. It necessitates the establishment of a separate accounting system for parking projects wherein all costs associated with parking would be segregated and prorated accordingly. Such costs typically include: security, utilities, supplies, maintenance, etc. Needless to say, the maintenance of such an account requires a considerable time investment.

The VA favors an amendment to section 5009 to permit the depositing of parking fees into the miscellaneous receipts of the Treasury. This approach would not require a significant change in the funding and management of parking facilities and would still allow for the recoupment of parking costs.

Question: (c). If you favor an approach different from the establishment of a revolving fund, please comment on the advantages and disadvantages of such an approach.

Answer: We would urge that the existing funding sources, i.e., construction and medical care appropriations, continue to be used for the construction, maintenance, and operation of parking facilities. Collected revenues would be covered into the Treasury as miscellaneous receipts. Using this approach, paid parking would be implemented with minimal effort and cost since there would be no change in the current accounting system. The disadvantage to this approach is that parking projects would continue to compete for funding in medical care and construction appropriations. However, this would be appropriate as parking then competes with all other needs through our prioritization system.

Question: 11. Your testimony (p. 9) stated that you believe "it is premature to make any decision to change the current approval process at this time, there may be options similar to the concept contained in this bill, which would provide additional flexibility. More time should be allowed, however, to study all of the ramifications of these options before a change is made to the existing procedure."

a. The issue of a State Home projects prioritization methodology was raised by the House more than a year ago. Section 107 of H.R. 505 passed by the House last year would have required the Administrator to prioritize State Home construction grant projects. How much more time would you need to review additional options and their ramifications?

Answer: We anticipate a report to the House Veterans' Affairs Committee on various options to fund State home construction grant projects by December 1986. We plan to consult with the National Association of State Veterans Homes (NASVH) in developing options which would best serve the VA and the States in the use of grant monies.

Question: b. Have you begun such a review? If not, when do you intend to do so?

Answer: The review began in June 1986 when the VA and the NASVH had its first meeting under the formalized Memorandum of Understanding which was signed on February 24, 1986.

Question: c. Please provide a list of the specific options you intend to review and your proposed timetable for completion of the review.

Answer: The options that were discussed at the June 1986 meeting of the VA and NASVH were:

1. Two Tiered Method - One list of grant requests to establish new State homes in States not currently providing State Home services and one list of grant requests from States to renovate or expand existing State Homes. This option was proposed by the Legislative Committee of the NASVH.

2. Modification of VA methodology for prioritizing VA Nursing Home Construction Projects (Bed Producing) and VA Methodology for Prioritizing Renovation Projects (Non-bed producing).

3. Split Appropriation Methodology - Part of the appropriation for bed producing projects and part for non-bed producing projects.

4. Current Method - First Come, First Served.

5. Development of a methodology with elements from Options 1-4.

6. Other options may be developed.

| Plan and Timetable For Options | Target Date | To |
|---|---|---|
| 1. Discuss options at the next joint meeting of the Va and VASVH | Completed | N/A |
| 2. Analysis of the options | 8/15/86 | N/A |
| 3. Draft final report and proposed legislation | 9/15/86 | N/A |
| 4. Policy Advisory Board Review | 10/16/86 | PAB |
| 5. CMD Approval | 10/23/86 | CMD |
| 6. Final report and legislative proposal to General Counsel | 11/07/86 | GC |
| 7. Brief Administrator | 11/21/86 | Administrator |
| 8. Propose Legislation to Congress | 12/04/86 | Congress |

Question: 12. Your testimony (p. 11) concerning section 8 of S. 2445 and the establishment of an ionizing radiation registry recommended "that as an alternative to the registry proposed in this bill, the VA develop a more limited registry which would, in effect, permit the VA greater access to the information which is already available.

a. Please provide a complete description of the "more limited registry", which you recommended, including a list of all the types and categories of information which you intend to include in the registry.

Answer: The main purpose of this registry is to access information that is currently being collected into a central source. Once that phase is completed we will add some additional information on each atomic veteran who visits a VA facility or when their survivors file a claim.

Information currently being collected that we will access includes:

a. The Defense Nuclear Agency's computerized list of veterans who have contacted them on the toll-free number. This information includes name, social security or service number, address (at time of call), location(s) and dates of exposure to ionizing radiation and estimate of dose received.

b. Patient Treatment File information from Medical Administration Service which includes dates and locations of hospitalization and key diagnoses.

c. Department of Veteran Benefits' Special Issue Rating System (SIRS) files which record claims filed and disposition. This file contains general identification information and most of the data found on the rating decision sheet.

When this information is accessed we will then ask each VAMC to send us the following information on veterans (or their survivors) who appear at the facilities:

- Name, Social Security Number, latest Address
- Name of Facility, Date(s)
- Chief Complaint
- Complaints related to ionizing radiation
- Major diagnosis
- Other diagnoses related to radiation
- Disposition

It is our feeling that this registry will be complete enough to allow the VA to respond appropriately and promptly to questions raised by the individual veterans or by concerned oversight groups.

Question: b. Have you begun developing the registry? If not, when do you intend to begin?

Answer: Yes. Computer hardware is on order and an employee has been selected and will report to duty in late August.

Question: c. How long will it take before the information is compiled to complete the registry?

Answer: Our goal for phase one (accessing data currently being collected) is December 1, 1986. As soon as that phase is completed, we will start adding the new data on veterans (or survivors) who visit VA facilities.

**QUESTION: 13. Please provide specific information as to the use of the authorities to make grants of up to $500,000 annually to the Veterans Memorial Medical Center and to provide contract care for Philippine veterans.**

**a. Specifically, how much was expended for each of these authorities for each of the past five years?**

**ANSWER:**

| | Grant-in-Aid | Contract Hospitalization[2] |
|---|---|---|
| FY 1982 - | $50,000[1] | $369,206 |
| FY 1983 - | 500,000 | 305,444 |
| FY 1984 - | 102,678 | 234,335 |
| FY 1985 - | 577,907 | 304,667 |
| FY 1986(to Date) | 475,000 | 168,135 |
| FY 1987(projtd) | 500,000 | 296,000 |

1) Limited to $50,000 per congressional action.

2) Represents total contract hospitalization cost within the Philippines the majority of which is through the use of the VMMC.

Note: Funds were provided under Public Law 97-72 through FY 1986, for assisting in the replacement and upgrading of equipment and in rehabilitating the physical plant and facilities of the VMMC. Funds are "two-year" monies.

**QUESTION: b. In the case of the grant funds, for what specific projects were the funds used?**

**ANSWER:** FY 1982 - No projects accomplished. Total grant equalled $50,000.

FY 1983 - No projects accomplished. First $500,000 grant year. Equipment only purchased.

FY 1984 - Repair and Replacement of Steam Condensate and Hot Water Lines, Phase one $82,107.

- Repair of Sewage Treatment Plant $20,571.

FY 1985 - General Repair of Outpatient Bldg. $134,131.

- Installation of Electric Fans in Patient Rooms and Treatment area - $1,192.
- Installation of Boiler $3,763.
- Installation of Steam Sterilizer $2,063

- Installation of Washer/Extractor Laundry Machine $1,364.

- Repair of patient bedside chairs and tables $27,142.

FY 1985 - General repair of Neuro-Psy. Ward #5 $154,081.

- Renovation of existing Laundry equipment - $40,746.

- Repair and replacement of steam/condensate and hot water lines, Phase II $88,938.

- Installation of Roof and water proofing building #3, $60,037.

- Renovation of main kitchen Medical Intensive Care and Coronary
Care Units $64,450.

FY 1986 - Pending Projects:

- Replace roofs and waterproof buildings, #8, 11 & 12 $150,000.

- Replace three elevators in buildings #10, 11 & 12 $90,000

- Renovate operating rooms and Surgical Intensive Care Unit,

$150,000.

- Renovate Supply/Warehouse Bldgs. $45,000.

- Upgrade Electrical Distribution System $40,000.

FY 1987 - Projected Projects:

- Renovate Chemistry and Pathology Labs, $44,000.

- Renovate Central Processing $75,000.

- General repair and replacement of water distribution system
$165,000.

- Renovate Nurses station wards #1-13 $36,000.

- Replace nurse call systems, Medical, Surgical wards and Intensive Care Units $180,000.

In addition to the above, replacement of the VMMC's Fire Alarm System, telephone system and emergency generator are needed at an estimated cost of $1.2 million. Since 1982, only maintenance and repair projects have been able to be accomplished.

QUESTION: 13c. How do you monitor the expenditure of these funds to ensure that the grant and contract care funds are actually used for the physical plant and for veterans health care.

ANSWER: Grant-in-Aid -

A committee comprised of the Director VA Regional Office, Chief Medical Administration Service and Chief Supply Service, who are U.S. VA employees, and key members of the VMMC review proposals from the VMMC. Proposals are prioritized based on urgency as well as availability of funds. When a project or a particular piece of equipment is identified, the Chief Supply Officer at the VA Regional Office issues a solicitation for bids. Once actual costs are identified monies are obligated in the same manner as in a regular VA Medical center within the Continental U.S. Normal inspections are conducted periodically to insure specifications are met.

Contract Hospitalization -

Contract Hospitalization is again handled in much the same way as the VA contract hospitalization program within the continental U.S. Eligible veterans are referred from the VA Outpatient Clinic to the VMMC. Obligations are set up based on expected length-of-stay, diagnosis and average daily costs. Upon completion of hospitalization a bill is submitted for payment to the VA Regional Office. It is reviewed for accuracy by the Chief Medical Administration Service and payment is issued. Frequently the Chief of Staff at the VA Outpatient Clinic, Chief Medical Administration Service and Director of the Regional Office make "rounds" within the VMMC to review progress of those veteran patients who are hospitalized.

Question: 14. The Houston inventory of acquired property has been allowed to grow to unmanageable levels and the projection is that several thousand additional properties are in the pipeline for VA acquisition.

(a). Given the existing statutory formula to be used when making the determination as to whether it is economically advantageous to take title to a specific property, why has the VA allowed the inventory to grow to the current level?

Answer: The growth in VA's property inventory in the Houston area is related to the increase in loan defaults in states with energy-related economies, especially Texas.

For some time, it has been difficult for our Houston office to obtain appraisals of properties for liquidation purposes that accurately reflect fair market value. In those instances where VA's appraisal has not reflected a rapidly declining market, VA has acquired some properties where the ultimate sales price was below the fair market value at the time of foreclosure.

In addition, there has been a delay in disposing of acquired properties because the expected surge in property sales as a result of declining interest rates has not occurred in this area.

Question: 15. What steps have you taken and do you intend to take to:

Answer: (a). Address the current Houston situation as well as--

Our Houston office has been working with real estate brokers and others on ways to stimulate sales activity and reduce property inventory:

* Reasonable offers below list price are considered for all properties listed for sale. This should be particularly helpful in a declining sales market.

* The major newspapers throughout its area are being used to list properties for sale and to conduct an ongoing general ad campaign to reach more of the house-buying public.

* Two large auctions have been held in the greater Houston area and more are being actively considered for the future.

* Additional staffing has been approved for the Property Management section.

* A team of computer experts was sent to the office to develop and implement a new computer system to track the station's inventory.

* In May, a team of realty experts was sent to help reduce workload backlogs in pricing properties, listing properties for sale, and offer processing. The team also made recommendations for procedural improvements within the office.

Question: (b). Prevent future acquisitions of property which will ultimately increase the loss to the Federal government?

Answer: We have emphasized to our Houston office the importance of considering factors which will provide a realistic approach to market conditions. Recent acquisition decisions reflect the consideration of these factors. In foreclosure sales held during the month of April 1986, our Houston office determined VA should pay a maximum claim and declined to accept property conveyances for 25 percent of the loans. This figure increased to 32 percent for sales held in the month of May and 35 percent for June sales. We believe that future acquisitons will be limited to those properties which are readily saleable.

Question: 16. Do you consider the length of time it will take to sell a specific property when making the decision to receive conveyance of the title to that property?

Answer: No. In determining net value and deciding whether to accept a conveyance, VA takes into account estimated costs based on the average time taken to sell acquired property. These are national averages and are not reflective of the costs in areas such as Houston. In Houston, management and disposition costs as a percentage of appraised value at foreclosure are 8.8%, and are below the national average. This reflects the lower average holding time in Houston, where it takes about 9 months to sell a VA-acquired property. We do not, however, believe it is possible to predict how long it will take to sell a specific property because of the number of variables involved, i.e., pricing, financing, marketing procedure, market fluctuations, and property condition.

Question: 17. Should the provisions of S. 2422 relative to this subject become law, what impact would you expect it to have on current practice regarding taking title to foreclosed properties?

Answer: Enactment of S. 2422 would enable VA offices that are having difficulty selling their inventory to acquire fewer properties. Regional office personnel would have the ability to refuse to accept conveyance of properties in any area where there was a question of being able to sell them profitably within a year's time.

Question: 18. How are the responsibilities for providing agency-wide Independent Living Services divided between DM&S and DVB?

(a) How does this division of responsibility meld the differences in training, experience, and other program responsibilities of DM&S and DVB rehabilitation staff?

Answer: DVB is responsible for providing independent living services to service-connected veterans found eligible for and entitled to benefits and services under chapter 31, title 38, United States Code. The purposes of the program authorized under chapter 31 are to "provide all services and assistance necessary to enable veterans with service-connected disabilities to achieve maximum independence in daily living, and to the maximum extent feasible, to obtain and maintain suitable employment." This definition of purpose establishes independence in daily living as a basic program goal for participants. Independent living services may be provided as necessary: (1) in evaluating the reasonable feasibility of vocational rehabilitation: (2) improving rehabilitation potential; and (3) as a part of a program of vocational rehabilitation. Additionally, through the pilot program, independent living services could be provided as a rehabilitation program for veterans for whom achievement of a vocational goal was not reasonably feasible.

Prior to the enactment of Public Law 96-466, DVB staff had extensive experience in providing selected independent living services to veterans in a vocational training program. Providing a program in which the goal is independence in daily living is a natural extension of their professional duties. Indeed, because of this integral relationship between vocational rehabilitation and independent living services, authority for the oversight of Federal-State independent living programs is vested in the same agency that has similar responsibiltiy for vocational rehabilitation programs.

Question: 19. The Independent Living Pilot Program was designed as an enhancement to rehabilitation services provided by Vocational Rehabilitation and Counseling Services in the Department of Veterans Benefits for service connected veterans not feasible for vocational training. The Department of Medicine and Surgery conducts several programs with independent living components, notably spinal cord injury and blind rehabilitation.

(a). Regarding Senator Cranston's proposal to make permanent the pilot program, since it is focused on medically related services, not vocational training, do you believe it would be useful to provide a joint authority to DM&S and DVB?

Would it be appropriate to provide DM&S with the primary authority to administer the program while DVB personnel work as consultants to DM&S? Or, would it be preferable to leave the program in Vocational Rehabilitation and Counseling and provide the independent services to veterans who may be feasible for vocational training?

Answer: We believe that the authority to provide independent living services should be granted to the Administrator generally rather than to a specific Department. This would provide an opportunity to assess different managment approaches to ensure the most effective and efficient delivery of services. We are not prepared at this time to make a final recommendation concerning whether ultimately the authority for providing independent living services should be jointly exercised by both DM&S and DVB or whether primary responsibility should be given to one Department with consultative responsibility being given to the other.

Question: 19(b). What are the disadvantages of extending the pilot program instead of making it a permanent authority?

Answer: The most significant disadvantage of extending the program as a pilot rather than as a permanent program is the reporting burden on field staff. However, due to the small number of participants who have completed the program, we do not have the information to evaluate the effectiveness of this program yet and, therefore, have recommended the extension of the pilot program.

Answer (cont.): DM&S provides medical care (including prevocational and independent living services) to both service-connected and nonservice-connected veterans. There are two types of DM&S programs: six VA medical centers received four staff to develop programs to meet the needs of the patients in their facilities or catchment areas. One facility expanded services to meet the needs of special patients in their district and the region. The Spinal Cord Injury Service receives $250,000 annually to use in contracting services for special independent living needs of spinal cord injured veterans. Most of these services are community oriented and focus on developing community networks and support for patients. This is especially emphasized in rural communities where resources are scarce. Both service-connected and nonservice-connected veterans can utilize these programs. Because of the limited resources, projects must be submitted annually in order to fund those which seem more comprehensive.

Question: (b) Should there be a greater link in Independent Living Program responsibility to provide agency-wide coordination for all Independent Living Programs?

Answer: A linkage currently exists between DVB and DM&S to assure the effective and timely delivery of independent living services. For example, DM&S independent living centers were utilized in providing services to veterans in the pilot program and DM&S staff referred service-connected veterans to DVB for consideration under chapter 31. Established channels for interdisciplinary input and review enable DM&S and DVB professional staff to collaborate in the planning of independent living programs. Agency wide coordination would not necessarily improve the program or assist in identifying more eligible veterans.

Question: 20. What is the extent of the problem that led the Administration to propose that the VA be given authority to collect military retired pay/survivors' benefit plan overpayments from VA compensation?

Answer: This proposal was put forward at the request of the Department of Defense. The VA has no current information regarding the extent of the problem.

Question: (a) How many military retired pay overpayments were created last year by retirees who have waived their retired pay to receive VA compensation?

Answer: The VA has no information regarding the number of overpayments last year. We suggest that this question be directed to the Department of Defense.

Question: (b). What was the total amount of those overpayments?

Answer: The VA has no information regarding the amount of those overpayments. We suggest that this question be directed to the Department of Defense.

Question: (c). How many retirees, having waived their retired pay to receive VA compensation, are not making required contributions to the Survivor Benefit Plan (SBP) or the Retired Servicemember's Family Protection Plan (RSFPP)?

Answer: The VA has no information regarding the current number of cases of delinquent premium payments. We suggest that this question be directed to the Department of Defense.

Question: (d). What was the total amount of those overpayments?

Answer: The VA has no information regrding the current amount of SBP or RSFPP premium delinquency or overpayments. We suggest that this question be directed to the Department of Defense.

Question: 21. Please describe the notice and due process you would provide a veteran retiree before you implemented an overpayment offset from his or her compensation.

Answer: The veteran retiree would be advised of the overpayment and would be provided with his or her waiver rights. These would include the right to be represented by an accredited representative of a veterans organization, the right to present new information, the right to a personal hearing, and the right to appeal the decision to the Board of Veterans Appeals. He or she would also be advised that the full amount of the benefits would be withheld to clear the debt unless they contacted the office within 45 days to arrange for a more satisfactory repayment plan or request a waiver or a hearing. The veteran is allowed to receive two full checks prior to starting deduction.

Question: 22. Have agencies other than the Defense Department asked VA to seek authority to administratively deduct debts to the government from VA compensation? For example, student loans, tax deficiencies, Civil Service overpayments?

Answer: The Internal Revenue Service has long had authority to collect Federal income tax delinquencies from VA benefits. Aside from the provisions of Title III, section 301, S. 2422, we are not aware of other proposals for recoupment of overpayments from VA benefits.

Question: (a). Would you support such a request and why?

Answer: The Veterans Administration and the Department of Defense have long worked together to minimize overpayments of retired pay/compensation and SBP/DIC. The same type of relationship does not exist between the VA and the administering agencies for other programs. Therefore, we would have to carefully review proposals from other agencies to determine whether we could support their positions. We would be very interested in determining whether such proposals included provisions for reciprocity. Would the other agency collect VA benefit overpayments from their benefits, if requested? As a matter of fact, the VA would prefer that Title III, section 301, S. 2422, include provision for recoupment of VA overpayments from retired pay or other Department of Defense programs, if there were no other source of collection.

Under our current benefit payment system we would not support such a request. From a strictly administrative viewpoint, we could not handle the workload associated with referring payments to other agencies from veterans' benefits on a monthly basis. This is not a problem with the SBP program because there is already a system in place where we can offset from a veteran's compensation or pension payment to apply to the SBP premium.

Question: 23. Please describe how the proposed change in fiduciary requirements requested by the VA and contained in S. 2422, would differ from the current VA practice?

Answer: Under current practice, a fiduciary is required to reveal the entire estate from any source only when the veteran is institutionalized and potentially subject to 38 U.S.C. 3203(b)(1). Otherwise, there is no clear-cut authority in law to compel a fiduciary who is in receipt of VA benefits on behalf of a VA beneficiary to reveal other income or assets of the beneficiary. While most fiduciaries comply voluntarily with some requests, others do not, and this causes some problems when it comes time to make a periodic assessment of the fiduciary's performance and the needs of the incompetent beneficiary.

VA field examiners make these periodic assessments. Experience has shown that such assessments are truly valid only when made in the context of the entire amount of income and other resources available to the beneficiary.

For instance, field examiners have no way of knowing whether a beneficiary's condition or environment may be improved through expenditure of appropriate amounts of the beneficiary's resources without the additional information. Although we cannot cite specific cases at this time, regular quality control reviews, by upper level management personnel in the VA's Central Office, have found cases wherein relatives acting in a fiduciary capacity have refused to reveal the beneficiary's other income and resources, either because they were increasing the veteran's estate for the benefit of potential heirs or because they felt it was just a family matter and not any of the government's business.

In some instances, misappropriation has been suspected, but without some mechanism to force full disclosure, we either maintained a status quo or found another fiduciary which is time-consuming and costly if not needed in the first place. Social Security benefits at times are the source of the other income and assets. When all income and assets are commingled, as they usually are, it seems to defeat the purpose of the VA's Fiduciary Program to prevent fraud, waste, and abuse to say that we will ensure the proper usage of only the VA Federal dollar and turn our heads with respect to the usage of other Federal dollars or private source estate to which an incompetent beneficiary may be entitled. We do not believe that such action is in the best interest of the beneficiary or the taxpayers of this country. With the passage of this legislation, refusal of a fiduciary to comply could be met with an administrative subpoena under the authority of section 3311 of title 38, U.S.C.

We further believe that once fiduciaries are aware that the VA's request for the full disclosure is law, most will readily comply, easing the administrative burden on the Agency and themselves. As far as the reporting burden on the public is concerned, we do not anticipate any real increase. In fact, there might even by a decrease because those fiduciaries who have refused in the past will not have to keep two sets of records, one for the VA and the other for non-VA assets.

Question: 24. How frequently do fiduciaries decline to provide information concerning non-VA income or assets held by the incompetent veteran in their care?

Answer: We have not kept a record of such incidents; however, one program manager contacted informally and who had experience at two different field stations roughly estimated that refusals occurred in no more than 5 percent of the cases.

Question: 25. In the past two years, have there been any instances of fiduciary fraud which would have been prevented had this proposal been law?

Answer: Again, we have not kept any statistics related to this question, but based on experience, we would have to say that the probability is very good that we would have found such instances.

## WRITTEN QUESTIONS FROM SENATOR MITCHELL TO THE VETERANS' ADMINISTRATION AND THE RESPONSES

Question: 1. Dr. Ditzler, your written testimony says that the enactment of S. 1536 would "appear to be contrary to the Congressional intent that the per diem payment program be a cost-sharing undertaking of the State and federal governments." Enactment of S. 1536 would not in any way change the VA's per diem payment program or the cost of that program would it?

Answer: The enactment of S. 1536 would not change the VA's per diem payment program or the cost of that program but would prohibit the States from considering VA per diem payments as an offset in determining medicaid reimbursements to State Veterans Homes. The result would be increased medicaid cost.

Question: 2. Your testimony says that enactment of S. 1536 would result in "no significant costs to the VA." Since the VA's role in operating State veterans homes consists of providing the per diem payments, and certifying that the homes provides adequate care to the veterans for which per diem payments are made, I fail to see how enactment of S. 1536 would cause any increased cost to the VA at all. Could you explain what costs to the VA would result from enactment of this legislation?

Answer: Upon further review of this issue, we now believe that there would be no additional cost to the VA.

Question: 3. Veterans in my state have argued for several years that it makes no sense for Congress to authorize this specific veterans benefit, the per diem payment, then turn around and allow this payment to be used to offset state and federal welfare funds with no benefit to the veteran. How do you respond to that criticism?

Answer: As I stated in my written testimony, the State Home Per Diem Payment Program is a cost-sharing program between the Federal and state governments. Enactment of S. 1536 would blur this cost-sharing concept, which the Congress intended, by raising the Federal share of the cost of care.